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West Virginia Medical JOURNAL

Volume 94 No. 1 *West Virginia State Medical Association* *January / February 1998*

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Seminars:

Pharmacology and Women's Health Issues
April 8, August 12, or
October 14, 1998
Robert C. Byrd Health Sciences Center of WVU/Charleston Division
4:00 to 6:30 p.m.

Topics:
- Contraceptives/New Progestin
- Hyperlipidemia
- Hormone Replacement Therapy
- Pain Control
- Homeopathic Alternatives
- Antidepressants
- Weight Loss Drugs
- Common Antibiotics

1998 Update for Cardiovascular Medicare and Coding
Joint sponsored by the West Virginia Chapter of the American College of Cardiology
Session I - Medicare Update
January 31, 1998
5:00 to 5:00 p.m.
Session II - 1998 Cardiovascular Coding Update
February 1, 1998
7:30 to 10:00 p.m.
Mountain Lodge Conference Center
Snowshoe, WV
N. Andrew Vaughan, MD

Cardiovascular Conference at Snowshoe
February 2-4, 1998
Mountain Lodge Conference Center
Snowshoe, WV
William H. Carter, MD, FACC

Scintimammography: The Next Step After Mammography
February 10, 1998
Robert C. Byrd Health Sciences Center of WVU/Charleston Division
5:30 p.m.
Mark S. Younis, MD

Teleconferences Noon - 1:00 p.m.

Antibiotics: Competent Use
February 5, 1998
Fred Kerns, MD

Advances and Diagnosis in Managing COPD
February 19, 1998
Juan M. D'Brot, MD

Developmental Considerations for the Neonate
March 5, 1998
Mary Justice, PT

Pediatric Cancer Update
March 19, 1998
Elizabeth M. Kurczynski, MD

On-Site Continuing Education Outreach Programs

Medical Ethics : Tamarack
Beckley, WV
February 4, 1998
6:30 p.m.
Robert T. Hall, PhD

Urinary Tract Infections
Man Appalachian Regional Hospital
Man, WV
February 18, 1998
6:00 p.m.
Joseph DeBord, MD

A.B.B.I.: A New Breast Biopsy Technique
Pleasant Valley Hospital
Point Pleasant, WV
February 26, 1998
Noon
Daniel S. Foster, MD

Urinary Stress Incontinence
Montgomery General Hospital
Montgomery, WV
March 4, 1998
12:30 p.m.
Paul H. Fulcher, MD

Update on Laparoscopic Procedures
Fayette County Medical Society
Montgomery, WV
March 4, 1998
6:00 p.m.
James P. Boland, MD

A.B.B.I.: A New Breast Biopsy Technique
Logan General Hospital
Logan, WV
March 13, 1998
11:45 a.m.
James W. Kessel, MD

New Diagnostic Procedure for Breast Cancer
Man Appalachian Regional Hospital
Man, WV
March 18, 1998
6:00 p.m.
Edward H. Tiley, III, MD

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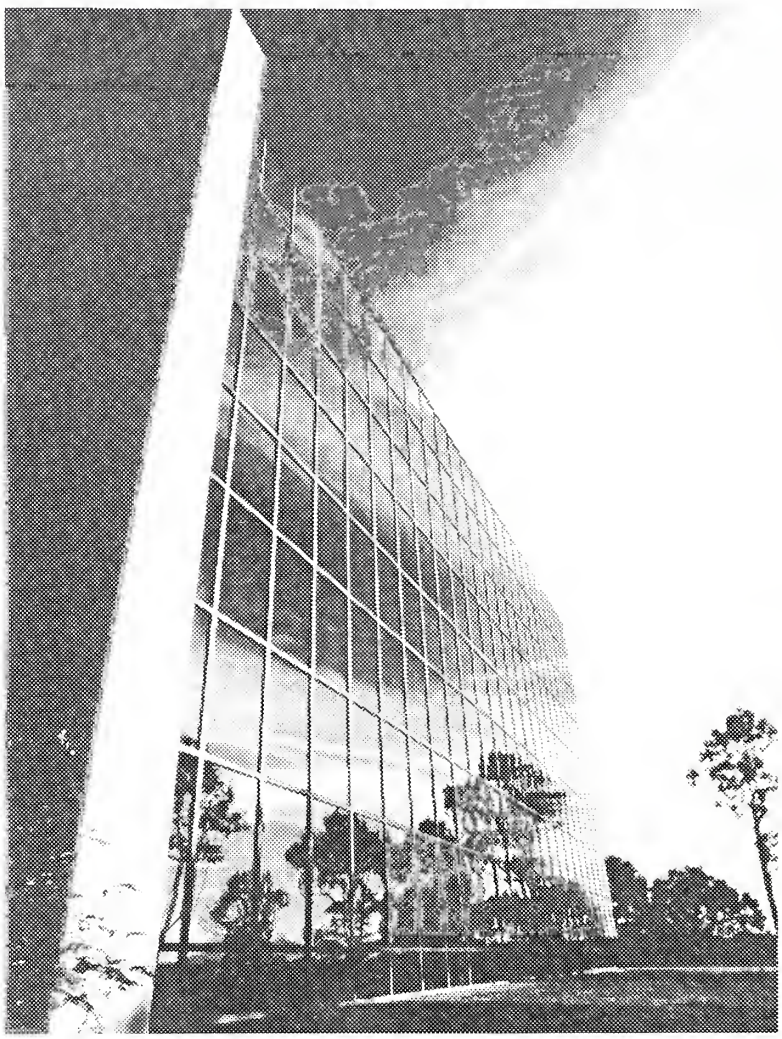

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On The Cover

Snowy farm scene along Route 4 in Lewis County.

Photo by Stephen J. Shaluta Jr.
West Virginia Department of Commerce.

Governor introduces tort reform legislation

Governor Underwood should be applauded for introducing to the Legislature S.B. 173 and H.B. 4026, *"Injured Consumers Bill of Legal Rights and Civil Justice Reform Act of 1998."* This is the first time a governor has submitted such legislation for consideration by our senators and delegates. Plaintiff attorneys are in full battle gear as they attempt to quash this effort by Governor Underwood.

All of us know how the judicial system of our state makes a mockery of "due process" in medical malpractice litigation. The premiums you pay for your malpractice insurance is testament to that.

West Virginia, a rural state, has premium rates as high as or much higher than our surrounding states, which are much more metropolitan with much larger populations.

To illustrate the West Virginia situation, I offer two irrefutable studies. The first involves the National Practitioner Data Bank. An analysis of the information collected in the first year the NPDA began showed that nationally, claims paid in malpractice litigation averaged 21.1 per 1,000 physicians. In West Virginia, the rate was 38 claims per 1,000 physicians. Only two states had higher numbers, Michigan at 39 and Montana at 42.

A second study done by the National Association of Insurance Commissioners asked the question - - *"Which states had the worst environment in which medical malpractice insurers did business?"* This national study covered 1989 through 1992, and West Virginia ranked in the top five worst states in three of the four years. It ranked number one all four years when compared to surrounding states.

The business community of our state is also prey for plaintiff attorneys and their unfettered search for the golden goose. The governor's bill addresses the following issues:

- **Moratorium on Attorney/ Insurance Adjuster Contacts:**

  Protects consumers suffering an injury from being contacted by an attorney or insurance adjuster for seven days after the event (such as an auto accident in which the consumer's family member was injured or killed).

- **"Plain English" Fee Disclosure:**

  Requires potential claimants to be given a copy of a Fee Information Fact Sheet by insurance adjusters, so they can compare fees and expenses when they seek a lawyer.

- **"Cooling Off" Period:**

  Gives claimants three days to cancel a contingency fee contract.

- **Payment Plan Protection:**

  Protects plaintiffs who receive periodic payments for their injuries from having their names disclosed to firms interested in converting their payments to a lump sum.

- **Comparative Fault - - Persons Liable According to Their Actual Responsibility:**

  Under the current principle of "joint and several" liability, a person who is only one percent responsible for an injury could be held liable for 100 percent of the damages. This encourages lawyers to look for a "deep pocket" or "easy mark" rather than the person principally at fault.

  The governor's bill would replace this with the principle of "comparative fault" by which each person is held liable for the percentage of his/her actual responsibility as determined by the jury.

- **Collateral Source - Inform Court of Duplicate Payment:**

  Allows the court to consider the amount of money that a plaintiff has received as compensation from other sources to cover his/her costs in determining damages, except for sources the plaintiff or his/her family had effectively paid for themselves.

- **Punitive Damages:**

Distribution

The purpose of punitive damages is to deter the defendant from engaging in the kind of bad conduct that caused the action, not to provide a windfall to the plaintiff or the plaintiff's attorney. The governor's bill, therefore, provides that 75% of the punitive damage award should go to the public, and the remainder to the plaintiff. The public share would be shared equally by: the Crime Victims Compensation Fund, the Volunteer Fire Protection Fund, various Senior Programs, the Breast and Cervical Cancer Fund, the Domestic Violence and Child Abuse Program, and the Drunk Driver Prevention Fund.

Formula for Maximum

The governor's bill has a formula for determining the amount of punitive damages that may be awarded, depending on the size of the employer.

For **small employers (25 or less employees or $5 million in annual revenues), the maximum is three times compensatory damages or $100,000 whichever is less.

For **large employers (all others), there is an indefinite limit on punitive damages: $1 million or three times the compensatory damages, whichever is **greater**. For example, if a large company did economic damage equal to $75 million, the punitive damages could be as high as $225 million.

- **Non-economic Damages - - Uniform Standard Established:**

Perhaps the most arbitrary aspect of the current liability system is the determination of "non-economic loss" to compensate the plaintiff for matters such as pain and suffering, emotional distress, loss of consortium, etc. Any two people, let alone any two juries or courts, may attach wildly different values to such damages.

The governor's bill provides a standard for such damages that depends on whether the non-economic loss was accompanied by physical injury.

Where there has been a severe physical injury, **in addition to damages awarded for economic loss**, the governor's bill would allow a plaintiff to recover an amount equal to the number of years of their life expectancy times the average annual wage in West Virginia, or $1 million, whichever is **greater**.

Just as plaintiff attorneys are lobbying with all their might on this issue, so must we. Malpractice litigation claims in this state are among the highest in the nation and are clearly out of control. This is our golden opportunity to set the issues straight.

It is our duty as physicians to support our governor and make sure our legislators understand just how crucial this legislation is. I will be sending each of you suggestions on ways you can make your voice heard.

Thomas H. Chang, M.D., F.A.C.S.

Health care by fiat

Who in the world ever started marketing health care? Whoever it was did far too good a job.

It's not just gullible soccer moms and their ilk with their dopey solutions to life's big and little problems who talk as though they and theirs can live forever in blessed good health if only they follow a good organic, low cholesterol, low fat, vitamin and mineral-enhanced low calorie diet in association with regular jogging, seatbelt and safety helmet use along with a stridently militant attitude toward smokers, drinkers, environmental polluters of any kind and, for many, anyone else who appears to be enjoying life a little too much. If you will take note, there are growing numbers of otherwise socially and politically conservative, straight-thinking, non-hysterical, non-melodramatic, ordinary citizens going about starting to say and think the same nonsense.

It's not that most of the things they advocate and agitate for are bad. Most are only good common sense items needing acceptance with some moderation and the remaindeer are merely scientifically unproven but harmless ritualistic charms promoted by someone making a fast dollar on a variety of magic potions. The really noteworthy thing to observe is their absolute self-righteousness and indignation directed at anyone who questions their credos in any way. They are *believers* who are so intent on preserving their own health that they become too terrified to question their own beliefs.

Terrified of what?

They will deny a fear of death, and, if the matter is pursued many, if not most, will have life insurance policies, cemetery lots, wills and other evidence they expect the world to go on after their demise. Most can think of dying without alarm or panic, but they apparently can't stand the thought of the helplessness and loss of control that now accompanies serious medical illness.

It is difficult for doctors to appreciate the loss of autonomy we inflict on patients while we go about saving their lives. We leave them no room for dignity. They become beholden to machines and the cold procedures of hospital routines.

Somehow, and surprisingly, during the process most patients develop an honest sense of gratitude toward their doctor, the director of the healing symphony, but none toward the process. They know that the process was an ordeal and something to be avoided in the future if at all possible. The ritualistic beliefs and the magic charms of the soccer moms have thus found a new mark.

Health is a shining jewel to be sought and valued by every living soul. There are other living jewels that can be admired and, for some, these take precedence over health, but not necessarily to the exclusion of health. Among these other jewels are autonomy, pleasure and freedom to make choices, even unhealthy ones.

As physicians, we are required to point out the tenets for maintaining good health. Perhaps it is even all right for us to scold a bit to stress the importance of our recommendations, but when recommendations for good health are taken up as ends to be enforced, it is time to start looking about at consequences other than to health.

Stephen D. Ward, M.D.
Editor

It's time to establish needle exchange program in WV

Injecting-drug use (IDU) is the second most common risk behavior for HIV infection and was directly or indirectly associated with 36% of the cases of AIDS in the U.S. through 1995 (1). In West Virginia, the proportion of AIDS associated with IDU has increased from 9% during the period 1985-1988 to 17% during the period 1993-1996 (2).

Needle exchange programs (NEPs), or syringe exchange programs (SEPs), have been proposed as an integral part of efforts designed to decrease the incidence of HIV transmission through IDU (3-5). In 1995, the National Research Council and the Institute of Medicine recommended that the following legislative barriers to NEPs be removed: the prohibition against the use of federal funds for NEPs; legal sanctions against the possession of injection equipment, needles and syringes; and the requirement of a prescription to purchase injection equipment (3).

In 1997, the National Institutes of Health (NIH) Consensus Panel concluded that NEPs do not promote drug use, do not encourage youth to use drugs, and do not result in an increase in used needles discarded in public places (4). This panel recommended lifting government restrictions on NEPs (4).

The effectiveness of NEPs in preventing HIV transmission has been inconsistently demonstrated (6-7). The three most compelling arguments for the effectiveness of NEP in the prevention of HIV transmission are the reduction of proviral DNA in syringes in the New Haven study (8-9), the reduction of HBV and HCV transmission in the Tacoma SEP study (10), and the persistently low prevalence of HIV in Australia. Conversely, several studies which were presented in July 1996 at the *XI International Conference on AIDS* in Vancouver demonstrated lack of effectiveness by NEPs in the prevention of HIV transmission.

Well-organized and small NEPs attract motivated IDUs who are willing to modify high-risk behaviors (6). Large and frequently less organized NEPs attract high-risk IDUs who are less likely to change their high-risk behaviors and may be using the NEPs to obtain needles and syringes (6).

A Needle/Syringe Access Program (NSAP) conducted by existing AIDS Prevention Centers should be established in West Virginia with the following components:

1. Participating IDUs must agree to HIV counseling and testing every six months. The counseling will emphasize sexual-risk reduction and injecting drug use harm reduction.
2. While maintaining strict confidentiality, the AIDS Prevention Centers will report IDU status and results of HIV antibody testing to the WV Bureau for Public Health.
3. The AIDS Prevention Centers will provide prescriptions for a one-month supply of needles and syringes with five refills to participating IDUs who meet the HIV counseling and testing requirements every six months.
4. Possession of needles and syringes obtained from pharmacies with prescriptions from the AIDS Prevention Centers should be legalized.
5. Referrals to drug treatment centers will be offered and encouraged but not required for participation.

This proposal for West Virginia falls short of other proposals to remove sanctions for the possession of injection paraphernalia and to remove requirements for prescriptions to purchase needles and syringes (3,5). A restricted program will attract motivated IDUs who are likely to modify high-risk behaviors whereas an unrestricted program may not be beneficial if the participants are not willing to modify their risk behaviors (6).

Enabling legislation will be necessary to enact the NSAP in West Virginia. Vigorous opposition to this proposal is anticipated. Access to clean needles and syringes has been advocated by national experts from the National Research Council, the Institute of Medicine, and the National Institutes of Health Consensus Panel. The time for debate by the general public, the public health community, and the medical community in West Virginia has arrived.

R. Wesley Farr, M.D.
Director
Rural STD/HIV Prevention Fellowship
Section of Infectious Diseases
Robert C. Byrd HSC of WVU
Morgantown

Ginamarie Foglia, D.O., M.P.H.
Fellow
Rural STD/HIV Prevention Fellowship
Section of Infectious Diseases
Robert C. Byrd HSC of WVU
Morgantown

(Please contact Dr. Farr for references listed in this letter.)

Special AMA Delegation Report

The repercussions resulting from the "Sunbeam episode," which have included the resignations of four top AMA executives, occupied much of the agenda at the recent AMA Interim Meeting in Dallas, December 8-11. A Board/Staff Liaison Committee and Ad Hoc Subcommittee was formed to deal with the issues and their report focused on identifying the nature of the AMA's relationship to corporations and how internal management systems might be improved to avoid similar problems in the future.

The recommendations made by this committee included the following items:

1. The Board of Trustees continue vigorous evaluation of corporate relationships for consistency with the principles that have been adapted by the Board in the past.

2. That all existing and new management processes continue to be assessed and improved to assure conformance with the prevailingly best practices.

3. That the board of Trustees report to the House of Delegates at the 1998 AMA Annual Meeting on additional steps that have been taken to assure that the AMA's decision processes are sound.

When appropriate and desirable, the AMA participates in corporate arrangements to support activities that will further the association's core purpose of promoting the art and science of medicine and the betterment of public health. The AMA does not endorse health or medical products or services that are produced by other companies and marketed to consumers unless decided by the Board of Trustees. No endorsement will be made on an exclusive basis in which the AMA does not design, produce or control. The AMA currently does not actively engage in any certification program or sponsorship programs. The chief executive officer is responsible for the review and implementation of each specific arrangement according to the principles and guidelines of the AMA. The executive vice president/chief executive officer is responsible for informing the board of trustees so that the board may approve corporate arrangements that have an economic and/or policy impact on the AMA. The AMA Board of Trustees is responsible for the operation of the AMA including the AMA's relationship with corporations and is subject to the principles and guidelines be approved by the House of Delegates.

A Task Force on Association/Corporate Relations of the Board of Trustees met on November 27 and planned several more meetings prior to the AMA's 1998 Annual Meeting. Other business items included:

***The AMA Budget for Fiscal 1998** - The budget showed that consolidated operation revenues were budgeted at $250 million, and the operating expenses including income taxes, were at $243 million, which leaves the AMA with budgeted operating revenues in excess of $7 million.

***Reimbursement for Telephone Advice to Patients** - The House of Delegates calls for the AMA to expand its current policy to advocate that all payers, in addition to Medicare, provide reimbursement for medical telephone calls, and that the AMA seek third-party reimbursement for telephone calls that are reasonable, properly documented in the patient's chart, and relate to the conditions for which the physician has previously examined the patient.

***Medical Fraud and Abuse** - The House of Delegates asked the AMA leadership to work with appropriate enforcement agencies to uncover intentional acts of misconduct and activities inconsistent with accepted medical practice, while continuing to challenge unfair enforcement practices.

***Protection for Physicians Who Prescribe Pain Medication** - The AMA supports the position that physicians who appropriately prescribe and/or administer controlled substances to relieve pain should not be subject to the burdens of excessive regulatory scrutiny, inappropriate disciplinary action, or criminal prosecution.

***Restricted Covenants in Residency or Fellowship Programs** - The House of Delegates approved a motion that the AMA adopt a policy and publicize to all teaching institutions the CEJA opinion, which states that it is unethical for a teaching institution to seek a non-competition guarantee in return for fulfilling its educational obligations. Physicians in training should not be asked to sign covenants nor to compete as a condition of their entry into any residency or fellowship program.

***Drivers Impaired by Alcohol** - The House of Delegates adopted a position that the AMA favors public information and education against any drinking by drivers; supports a 0.04% blood alcohol level as illegal for driving; and urges incorporation of that provision in all state drunk driving laws. In addition, the members support 21 as the legal drinking age; support strong penalties for providing alcohol to persons younger than 21; urge adoption by all states of legislation calling for administrative suspension or revocation of a driver's license after he/she is convicted for driving under the influence; support mandatory revocation after a specified number of repeat offenses; and encourage industry efforts to develop a safety module that thwarts operation of a car by an intoxicated person.

***HIV Infection** - The House of Delegates requested support from the AMA leadership for requiring that HIV infection be a reportable disease. The members also urged that individuals infected with HIV and their potential contacts be advised of methods to avoid or reduce the chance of infection or disease progression.

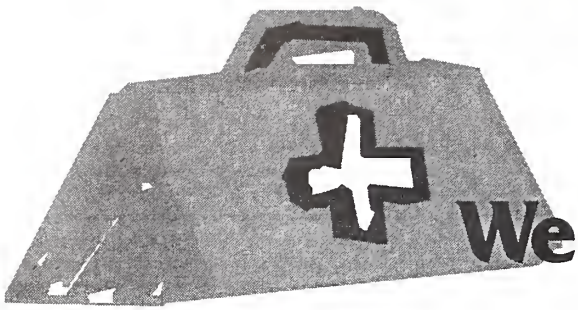
***AMA Council on Scientific Affairs** - The AMA Council on Scientific Affairs, in conjunction with the National Safety Foundation and appropriate medical specialty societies, made recommendations regarding the organization of systems and protocols of care for acute stroke therapy, with attention to patient safety.

***Managed Care Length of Stay Guidelines** - The House of Delegates asked the AMA leadership to support the concept that the treating physician's judgment is paramount in decisions regarding appropriate length of stay, and also that the AMA oppose physician "termination without cause" provisions in managed care contracts that do not contain due process protections and appeal processes to an independent panel. Furthermore, that the AMA continue to support the enactment of comprehensive legislation that addresses the wide range of patient protection and physician fairness issues, such as disclosure of health plan information to enrollees and prospective enrollees, utilization review and grievance procedures, due process in physician selective contracting decisions, and physical involvement in health plan medical policies. They also asked that the AMA seek elimination of clauses in managed care contracts that allow plans to refuse to pay for provisions of covered services for the sole reason that required notification of these services was not reported in a timely manner.

***National Practitioner Data Bank** - The House of Delegates asked the AMA to re-emphasize its policy to abolish the National Practitioner Data Bank.

***Retention of Hospital Privileges for Primary Care Physicians** - The House of Delegates requested that the AMA look into the retention of hospital privileges for primary physicians. The members asked the AMA to support the principle that hospitals may not limit medical staff privileges based on physician membership at a different hospital.

Constantino Y. Amores, M.D.
WVSMA Delegation Leader



The Search Is On for Outstanding West Virginia Physicians

Why we honor our physicians

It is once again that time of year. Time to honor and recognize a fellow physician or outstanding individual who has made an invaluable contribution to medicine or health care in West Virginia. When nominating a fellow physician or a member or your community, please remember that this is an opportunity to recognize someone who has done excellent service to his or her community and has been an asset to the state of West Virginia. While honoring others we are all encouraged to act similarly.

The Awards

We are now accepting nominations for the Wyeth-Ayerst Physician Award for Community Service, the Rural Health Physician of the Year and the West Virginia Presidential Citation. The following awards will be presented at the 131st Annual Meeting at The Greenbrier, August 26-29.

The **Wyeth-Ayerst Physician Award for Community Service** recognizes a physician who has uniquely contributed to the community.

The **Rural Health Physician of the Year** recognizes a physician who offers exceptional medical care to patients in smaller, rural areas.

The **Presidential Citation** is awarded to a non-physician who has made a contribution to medicine or health care in West Virginia. Nominees could include reporters, volunteers, hospital staff, etc.

Act Now!

Take a moment to recognize our West Virginia physicians by nominating them for these prestigious awards. I will be happy to send you a nomination form and description sheet for the awards.

Please send me a nomination kit:

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Company

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Address

_____

City/State/Zip

Deadline for nomination is May 1, 1998.
Please send completed form to Christina R. Dixon, WVSMA Public Relations, P.O. Box 4106, Charleston, WV 25364. Questions, please call (304) 925-0342 or fax to (304) 925-0345.

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- Slides should be taken on a low-speed color film, preferably 64ASA or lower. Color photographs should be 8" x 10" in size.
- Both slides and photographs must be vertical in orientation. All slides and photographs should have a solid or unobtrusive background toward the top in order to accommodate the masthead.
- The name, address and telephone number of the photographer must accompany the slide or photograph.
- Any slide or photograph submitted becomes the property of the West Virginia State Medical Association. Slides and photographs will not be returned.
- Items may be sent to: **Nancy L. Hill, *WV Medical Journal*, P.O. Box 4106, Charleston, WV 25364.**

Surveillance testing in patients with early stage breast cancer: A review

STEVEN J. JUBELIRER, M.D.
Senior Research Scientist, Camcare Health Education and Research Institute; and Clinical Professor, West Virginia University School of Medicine, Charleston Division, Charleston

Abstract

The optimal breast cancer surveillance testing program for early-stage breast cancer patients has not yet been defined. The results of three surveys evaluating patterns of follow-up have indicated that most physicians practice some level of routine surveillance testing (history, physical examination, and yearly mammogram), but there is extreme variation in follow-up practices from physician to physician, especially in the use of blood tests, bone scan, and chest X-ray. The results of numerous retrospective studies and two large randomized prospective studies have indicated that: 1) most recurrences are detected by the history and physical exam; and 2) intensive surveillance testing of asymptomatic patients does not improve overall survival. Several studies on the psychosocial impact of follow-up testing have indicated that: 1) patients desire frequent follow-up visits; 2) patients undervalue the clinical exam and overestimate the value of laboratory and X-ray studies in detecting recurrences.

Introduction

The major reason for follow-up after curative resection of early stage cancers is to detect recurrent or metachronus tumor symptoms. The strategy is based on the assumption that early detection improves the chance for curative treatment of relapse and thus increases disease-free survival and/decreases suffering from local recurrence.

It is unknown, however, if, or to what extent, follow-up after surgery benefits the patient. This article addresses these issues by reviewing the literature pertaining to the value of follow-up after surgery.

Published studies

The cancer surveillance practices of community physicians is largely unknown since only three surveys evaluating patterns of follow-up of breast cancer patients have been published (1-13).

In the study by Rickert-Boe (1), a cross-sectional survey of 773 members of the American Society of Clinical Oncology (ASCO) residing in Washington and Oregon was conducted. Three scenarios, each describing a patient with cancer of the breast, colon, or prostate, were included. Participants were asked to indicate the frequency with which they would order seven different diagnostic tests in the routine follow-up of such patients.

In the surveillance of a 40-year-old woman with stage II ($T_2N_1M_0$) estrogen-receptor negative breast cancer, 80% of respondents would perform a complete blood count (CBC), and liver enzymes (LFT's) at 3- or 6-month intervals. Annual mammographic screening was ordered by 96% of respondents. Half of the respondents would order a chest X-ray yearly and 60% would order bone scans for clinical indications only. The greatest variety of use was observed with carcinoembryonic antigen (CEA) and CA 15-3 testing.

In a study by Loomer et al (2), 80 members of the Piedmont Oncology Association were polled regarding their follow-up of women with low and high-risk early stage breast cancer. A history and physical exam was performed every 3-6 months for the first two years by 90% of respondents and for five years in high-risk patients (i.e., positive axillary nodes and tumor size $\geq$ 3 cm) by 66% of respondents. A CBC and LFTs were performed every six months for five years by 90% of the respondents. A chest X-ray and mammogram were performed yearly by 70% and 95% respectively. A CEA level was ordered by only 35% of respondents.

Simon et al (3) surveyed a random sample of physician members of ASCO about their routine follow-up of postmenopausal women with early stage breast cancer. In the first year after treatment, respondents performed, on average, one physical exam every three months, one blood panel (CBC, LFT's) every four months and one chest x-ray every nine months. In addition, a CEA level, CA-15 level, bone scan and CT scans were ordered by 38%, 21%, 28% and 4% of respondents respectively. A history and physical examination, chest x-ray, CBC and LFTs were performed at year three and year five after diagnosis by at least 80% of respondents. A bone

scan was ordered at year three and year five from diagnosis by 20% and 11% of respondents respectively. A serum CEA level was ordered at year three and year five from diagnosis by 35% of respondents.

It can be concluded that although physicians (e.g., oncologists, surgeons, etc.) practice some level of routine surveillance testing of their early stage breast cancer patients, there is considerable variation in follow-up practices. Unfortunately, the optimal cancer surveillance testing program for breast cancer patients has not been defined.

Cancer morbidity and mortality

A large number of trials have suggested that the majority of cancer recurrences are detected by the physician or the patient from signs and symptoms noted during routine follow-up visits.

Schapira (4) summarized the method of detection of breast cancer in 442 patients from four studies. Eighty-six percent of the recurrences were first detected by symptoms or physical examination. Bone scan, chest X-ray, blood chemistries, and mammography first detected 3.4%, 2.7%, 5.9%, and 2.0% of recurrences respectively. He concluded that surveillance testing could be limited to periodic history, physical examination, and mammography. Mammography was included because it is useful to detect second primary cancers which are often a treatable recurrence.

Vestergaard et al (5) reported results concerning the value of yearly chest X-rays in patients with stage I breast cancer. The authors found otherwise unsuspected malignant disease in only 0.25% of 1,599 chest exams. Similar results were reported by Logager (6), who used routine chest X-rays for the follow-up of stage II breast cancers. Unsuspected malignancies were diagnosed in only 1.3% of scheduled chest X-rays of asymptomatic patients in that study. In three other studies, the incidence of malignant disease on chest X-ray in asymptomatic early stage breast cancer patients ranged from 0.25% to 0.4% (7). The value of bone scans in asymptomatic patients with early stage breast cancer was summarized from four studies by Musumeci (7). In those studies, the incidence of metastases ranged from 0 to 0.6%.

A number of studies have suggested a lack of survival benefit in patients with early stage diagnosis of asymptomatic recurrences. Rutgers et al (8) analyzed the time from first diagnosis to recurrence in 148 women with breast cancer who relapsed during close follow-up, 114 of whom (77%) were symptomatic and 34 of whom were asymptomatic at the time recurrence was detected. The disease-free interval was the same for both groups.

Wagman et al (9) studied 208 women with breast cancer who were closely followed after treatment. Sixty-four patients had recurrences; 13 developed primary cancers in the contralateral breast and 51 developed metastatic disease. Although more than half of the recurrences were detected by routine follow-up exams, the survival of those diagnosed at routine follow-up examinations, was the same as that for patients with symptom-detected recurrence when those with second primary cancers were excluded.

Tomin and Donegan (10) examined the medical records of 1,230 women with breast cancer who were treated with curative intent and for whom close follow-up was recommended. Breast cancer recurrences occurred in 248, of whom 54 had regular follow-up and 194 had irregular follow-up. Survival time after recurrence was the same in both groups. In studies by Broyn et al (11) and Zwaveling et al (12), survival of patients whose recurrences were detected during routine follow-up was the same as that for patients with symptom-detected recurrences.

The best evidence pertaining to the usefulness of routine follow-up comes from two large randomized trials (13,14) which examined the effects of follow-up testing on the survival of women with breast cancer who received curative treatment (Tables 1,2).

The study by the Interdisciplinary Group for Cancer Care Evaluation (GIVIO)(13) involved 1,320 women with stage I, II, and III unilateral primary breast cancer. These patients were randomly assigned to an intensive surveillance which included physician visits and performance of bone scans, liver sonograms, chest X-rays and lab tests at predefined

Table 1: Randomized clinical surveillance in 655 patients with early stage breast cancer: Givio Study (13)

Intensive Surveillance	Controls
FOLLOW-UP (Median: 71 Months)	
History/physical - q 3 months x 2 years	Same
Mammogram - yearly	Yearly
Quality of life assessment - 6, 12, 24 and 60 months	Same
Blood tests - q 3 months x 2 years then q 6 months (CBC, LFTs)	None
Chest X-ray q 6 months	Not done
Bone scan yearly	Not done
Liver ultrasound yearly	Not done
RECURRENCE	
Local 4.8%	5.4%
Distant 19.3%	19.1%
OVERALL SURVIVAL 80%	82%

Table 2. Randomized trials of clinical surveillance in 622 patients with early stage breast cancer: Del Turco et al (14).

Intensive Surveillance	Control
FOLLOW-UP	
History/Physical - every 3 months x 2 years, then every six months yearly	Same
Mammography - yearly	Yearly
Quality of life assessment - not done	Not done
Blood tests - every 3 months x 2 years, then every 6 months	None
Chest X-ray - every 6 months	None
Bone scan - every 6 months	None
Liver ultrasound - not done	Not done
RECURRENCE	
Local alone 8.8%	7.9%
Distant 26.4%	20.1%
OVERALL SURVIVAL 81% (71 months median follow-up)	80%

intervals or to a control regimen in which patients were seen by their doctors at the same frequency, but only clinically motivated tests were performed. Both groups received a yearly mammogram to detect contralateral breast cancer. After a median follow-up of 71 months, no difference was apparent in overall survival with 132 (20%) and 122 (18%) deaths in the intensive and control groups, respectively. Perceptions of overall health and quality of life, emotional well-being, body image, social functioning, symptoms, and satisfaction with care) at 6, 12, 24, and 60 months of follow-up did not differ.

The study by Del Turco et al (14), randomized patients with stage I and II breast cancer into these groups:

1. An intensive follow-up group in which a mammogram was performed annually, a chest X-ray and bone scan every six months, and clinical exam three times a year for the first two years and twice yearly for the following three years,
2. A control group which required only regular clinical and mammographic examinations.

In that study, a significant difference between the two 5-year relapse-free survival curves was observed with patients in the intensive follow-up group showing an earlier diagnosis of recurrences. However, the estimated mortality was 18.6% in the intensive follow-up group and 19.5% in the clinical follow-up group. Survival curves showed no difference between the two groups. The difference in recurrences was due to an excess of isolated bone and intrathoracic metastases in the intensive surveillance group compared to the controls (bone - 83 vs. 53 recurrences; lung - 28 vs. 18 recurrences).

These two studies show that most recurrences are detected by reviewing the patient history and performing a physical examination, and that intensive testing does not improve the outcome of women who relapse. As a result of this information, several major cancer centers created guidelines to outline appropriate follow-up plans for asymptomatic patients. Examples of guidelines by the Mayo Clinic (15) and the Stalian Working Group (16) on the clinical aspects of follow-up are found in Tables 3 and 4.

Psychological aspects

During the past two decades, an extensive research and clinical work has documented the psychosocial impact of a cancer diagnosis and the treatment that follows. Until two recent studies (13,17), there has been little in the literature that has directly addressed the question of the psychosocial impact of follow-up care on breast cancer patients.

Muss et al (17) reported the results of a cross-sectional survey completed by 101 consecutive breast cancer patients, 46 of whom had localized disease, attending an outpatient clinic at a university hospital. They developed a questionnaire to examine the perceived efficacy of follow-up care and concluded that:

1. The majority (70%) of localized disease patients desired regular and frequent physician visits (at least every 3-6 months);
2. Most patients were knowledgeable about the tests that they received, but consistently overestimated the value of lab and radiologic studies and underestimated the value of the medical history and physical exam;
3. The majority of patients believed that early detection of metastases improved long-term outlook and a chance for cure;
4. Most of the patients were unfamiliar with the limitations of many of the follow-up studies, reflecting the fact that physicians spend little time discussing the costs, benefits, sensitivity, and specificity of these studies.

In the studies by the GIVIO Investigators (13), women were asked about their preferences for follow-up care. More than 70% reported that they wanted to be seen often by a physician and undergo tests even if free of symptoms. This preference was stated by women in both the intensive and non-intensive surveillance arms, and is consistent with the findings of Muss et al.

Table 3. Follow-up guidelines for early stage breast cancer: Mayo Clinic (15).

	History/Examination*+	Chemistry	CBC	Chest X-ray	Mammogram#
Node-Negative, No adjuvant therapy	Yearly	Yearly	Yearly	Yearly	Yearly
Patients who received adjuvant chemotherapy receiving Tamoxifen	Every 6 months for 2-4 years, then yearly	Every 6-12 months for 2-4 years then yearly	Yearly	Yearly	Yearly
		No tumor markers or bone scan recommended routinely			

* *Consider initial history/physical exam 3-4 months after completing therapy.*

\+ *For patients who have had a breast-preserving procedure, a history and breast exam are recommended every six months for the first 5 yrs.*

\# *An additional mammogram should be done approximately 6 months after completion of locoregional therapy in patients who have had breast-preserving surgery.*

Table 4. Follow-up guidelines for early stage breast cancer: Working Group on the Clinical Aspects (16).

Time Since Surgery	Clinical Exam	Lab Studies (CBC, LFTs)	Mammography	Liver CT/ ECHO	Chest X-ray	Bone Scan	Marker
< 2 years	Every 3 mts.	Uncertain	Yearly	Inappropriate	Not indicated	Not indicated	Not indicated
2-5 years	Every 6 mts.	Uncertain	Yearly	Inappropriate	Not indicated	Not indicated	Not indicated
> 5 years	Yearly	Uncertain	Yearly	Inappropriate	Not indicated	Not indicated	Not indicated

These studies suggest that patients undervalue follow-up visits and have been led to believe that lab and radiographic studies are better at detecting recurrent cancer. It is vital to reassure patients that lab and X-ray studies seldom detect a recurrence before clinical symptoms, and that survival and prognosis are rarely changed by detecting a resurrence early. Similarly, we must listen closely to their comments during follow-up visits and perform indicated tests then, instead of at pre-specified intervals.

Addendum

Since the publication of this paper, the American Society of Clinical Oncology has published guidelines for resectable breast cancer. These include regular physical exam (pelvic exam also for patients on Tamoxifin) and yearly mammograms, no other testing indicated.

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CT demonstration of resolution of hepatic lesions in HELLP Syndrome: A case report

CHARLES MUCHNOK, M.D.

JEFFREY P. HOGG, M.D.

DEBORAH S. GRANKE, M.D.

Department of Radiology, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown

Abstract

This article decribes the CT appearance of the liver in a patient with HELLP Syndrome in the acute and resolving phases of the disease. In the acute phase, computed tomography showed multiple confluent hypodensities in the left and right hepatic lobes, ascites, and subcutaneous abnormalities.

Introduction

HELLP Syndrome is an uncommon syndrome first described by Weinstein in 1982. It is a severe complication in a small number of patients with pre-eclampsia/eclampsia, and consists of hemolysis, elevated liver enzymes, and low platelet count.

Since acute and delayed subcapsular hematoma rupture has been reported and is often fatal, CT is useful in the initial evaluation and may be important as a cost effective follow-up tool to indicate resolution.

Case report

A 33-year-old black female G_5P_0 presented at 26 weeks gestation with dyspnea, fever, hypertension, and right upper quadrant (RUQ) pain. Her exam revealed edematous facies, RUQ tenderness, a 2+ pedal edema, a BP of 193/123, and proteinuria was 3+ severity.

Her lab report showed:

*platelets (plts) 40,000 (normal 140,000 - 450,000);
*prothrombin time (PT) 12s (normal = 11-13s);
*partial thromboplastin time (PTT) 27.5s (normal 23.5-31.5);
*total bilirubin 1.7 mg/dl (normal = 0.1-1.0 mg/dl) and (unconjugated 1.3 mg/dl);
*gamma glutamyl transferase (GGT) 80 u/L (normal 10-42);
*alkaline phosphatase (AlkP) 284 u/L (normal 40-130);
*lacate dehydrogenase (LDH) 3,750 u/L (normal 280-600);
*asparate amino transferase (AST) 431 u/L (normal = 8-37); and
*alanine amino transferase (ALT) 305 u/L (normal = 4-40);

The ultrasound of RUQ showed normal hepatic parenchyma. Due to worsening coagulation factors (Plts to 20,000, PT to 13.5s and PTT to 45s), a C-section was performed, followed by exploratory laparotomy.

She delivered a 660 gm infant with low APGARs, which died after several weeks due to prematurity and its complications. Intraoperative evaluation demonstrated an enlarged firm liver with an approximately 5 cm mass involving the left lobe.

Postoperatively, the patient's liver function tests continued to increase dramatically (LDH = 26,900 u/L; AST = 4,286 u/L; and ALT = 179 u/L). Repeat ultrasound exam of the RUQ showed heterogeneous echogenicity of the left hepatic lobe. Contrast enhanced CT of the abdomen showed multiple confluent wedge-shaped hepatic lesions in the left lobe. Contrast enhanced CT of the abdomen showed multiple confluent wedge-shaped hepatic lesions in the left lobe (Figure 1a) and scattered small hypodensities in the right lobe, ascities and subcutaneous edema (Figure 1b).

Her recovery was complicated by marked thrombocytopenia and elevated liver enzymes. However, at three weeks after admission, her liver enzymes and platlet count returned to normal and her proteinuria resolved.

She was discharged in good health and remained symptom-free. A repeat contrast enhanced CT scan of the abdomen performed four weeks postpartum showed essentially complete resolution of hepatic lesions with a few tiny residual hypodensities in the anterior segment of the right lobe (Figure 2a) and left lobe and resolution of swelling in the hepatic left lobe (Figure 2b).

Discussion

Preeclampsia is a common cause of maternal and fetal morbidity and mortality in pregnancy. The classic triad of preeclampsia is described as severe hypertension, proteinuira, and edema. If severe, CNS abnormalities, pulmonary edema, and hepatic involvement may occur.

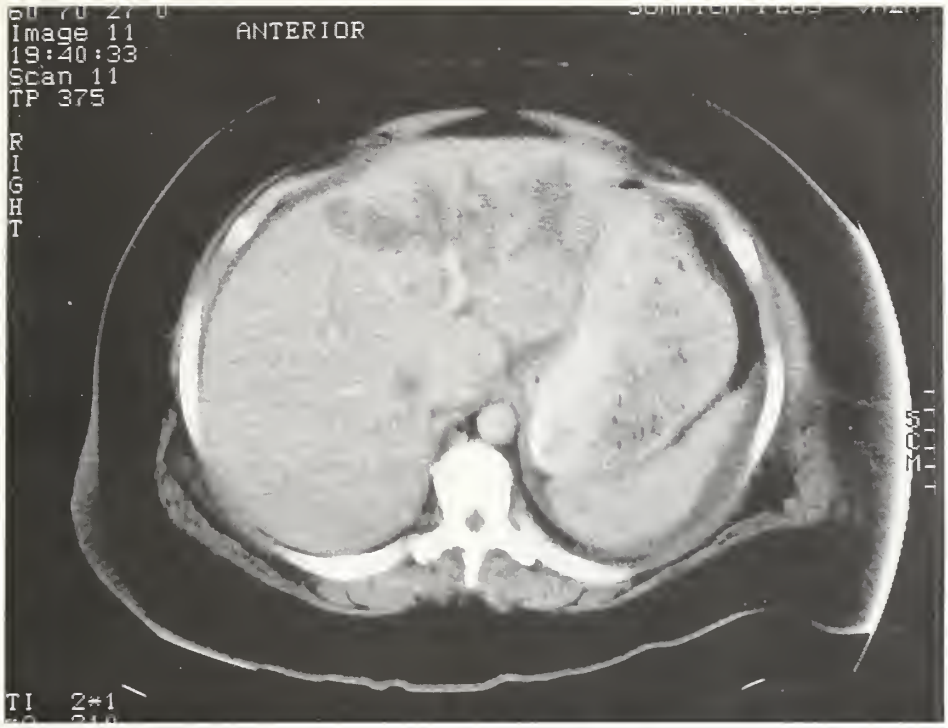

Figure 1a. Contrast enhanced axial CT section through the upper abdomen shows multiple confluent wedge-shaped hypodensities in the swollen left hepatic lobe, typical of HELLP. Absent enhancement in the lesion reflects impaired delivery of contrast in the lesion, due to intrahepatic vascular compromise (sinusoidal occlusion).

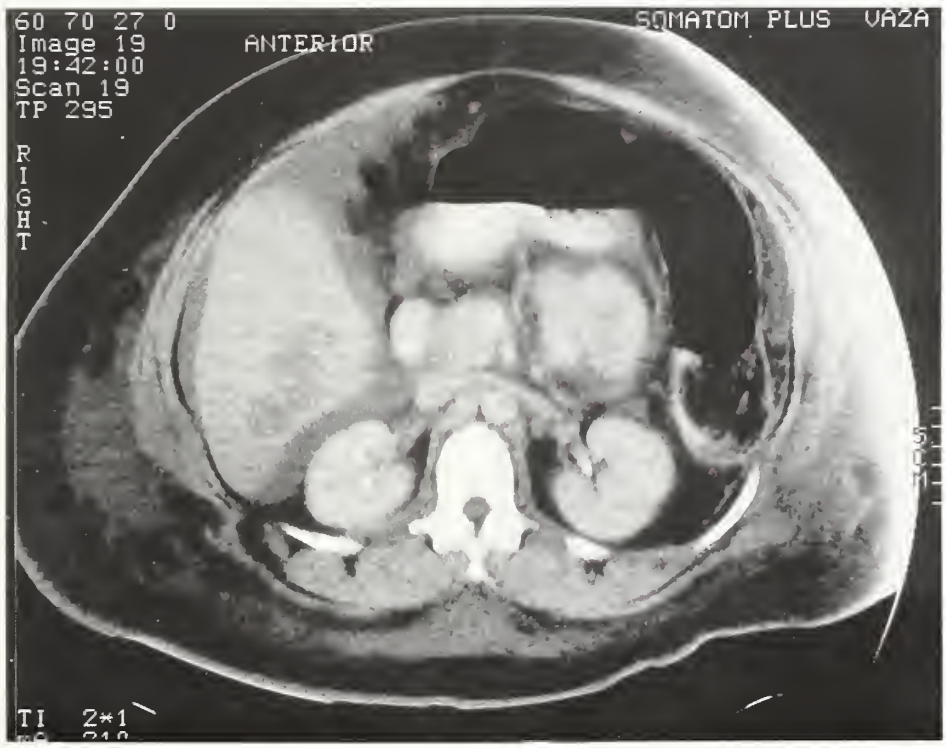

Figure 1b. CT section through more inferior part of the liver indicates hypodense peripheral and deeper HELLP lesion in the right hepatic lobe. Subcutaneous edema and ascites are visible in this patient who clinically presented with 3+ proteinuria and marked hepatic enzyme disturbance.

Hepatic abnormalities associated with pregnancy have been reported in the literature for many years (1-5). The term HELLP Syndrome (Hemolysis Elevated Liver Enzymes and Low Platelets) was coined by Weinstein in 1982 (1).

The etiology of HELLP syndrome remains obscure. It is most often described as a severe complication of preeclampsia-eclampsia which occurs in 2-12% of these patients (2). Patients with HELLP Syndrome usually present with RUQ pain (90%), nausea and vomiting (50%), and non-specific viral-like symptoms. Most patients (90%) give a history of malaise for several days prior to presentation (6). As in our patient's case, elevated liver enzymes, thrombocytopenia, and hemolytic anemia are the typical lab findings.

Histopathologically, the usual hepatic findings in preeclampsia-eclampsia are sinusiodal occlusion with fibrin clots and proximal hemorrhage into the space of Disse. This can lead to hepatocellular injury, degeneration and hepatocellular necrosis (3). In severe cases, subcapsular hematoma can form which can lead to hepatic capsule rupture and death by massive internal bleeding. CT is often used to study the liver for these complications.

Ultrasound is often the initial imaging study in the pregnant patient with suspected hepatic abnormality due to excellent definition of hepatobiliary structures without fetal radiation exposure. Sonography can evaluate for cholecystitis/cholelithiasis or acute fatty liver of pregnancy. These are disease entities which may present with similiar clinical symptoms and signs (6). However, findings of altered echogenicity on ultrasound are nonspecific.

In comparison, hepatic abnormalities including hepatic ischemia or infarction and subcapsular hematoma associated with HELLP, with or without rupture are well depicted by CT (6-9). Also, the findings of cholecystitis/cholelithiasis and

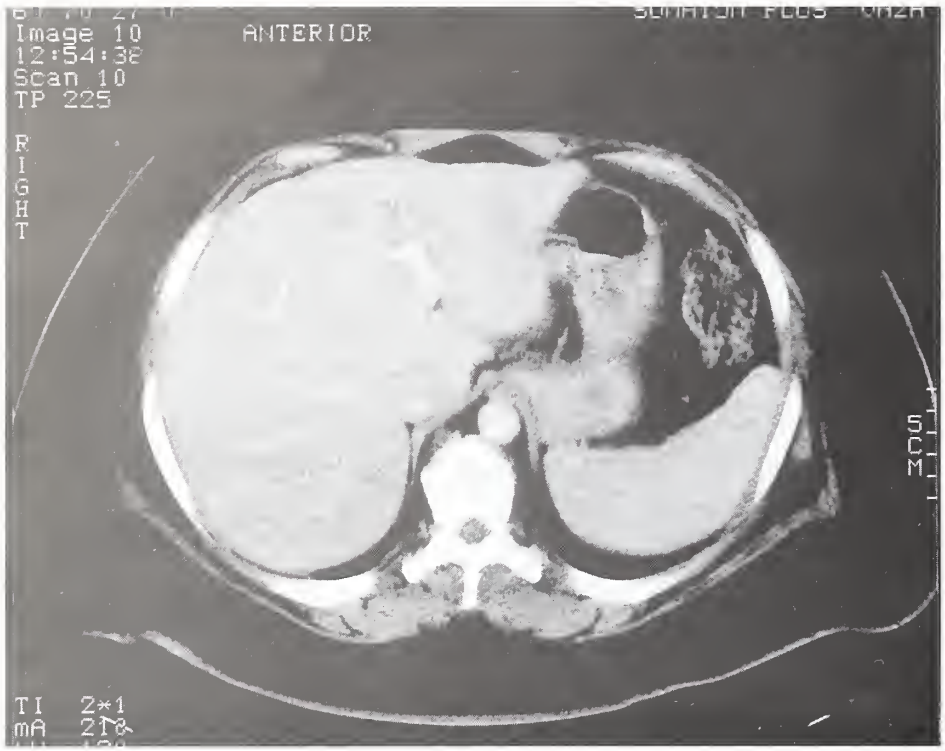

Figure 2a. Follow-up CT section showing complete resolution of the lesion in the left hepatic lobe. This CT section was taken four weeks after the one in Figure 1a.

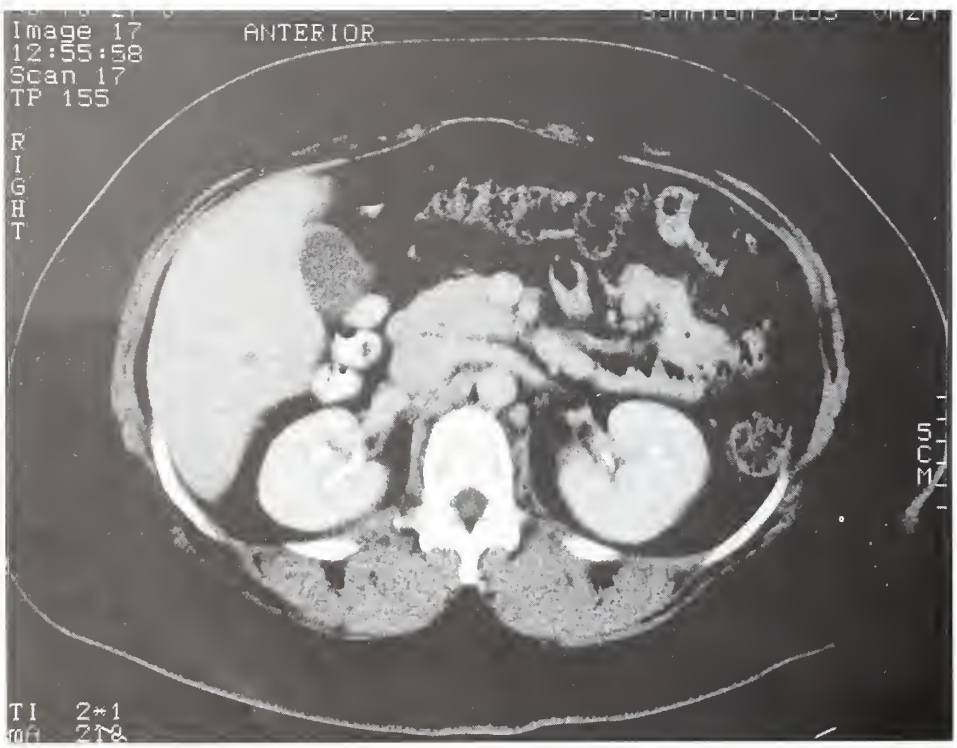

Figure 2b. From the same follow-up CT series as shown in Figure 2a, but with an image which more inferiorly demonstrates only tiny residual right hepatic lobe hypodensity. Abdominal asites and subcutaneous edema are now absent, likely reflecting the clinical resolution of both the proteinuria and the hepatic enzyme abnormality.

acute fatty liver of pregnancy can be differentiated from the findings associated with HELLP on CT (6). Therefore, computed tomography is generally accepted as the study of choice to evaluate the liver in HELLP Syndrome.

CT findings of lack of contrast enhancement and mass effect with geographic or wedge-shaped areas of diminished density suggest hepatic ischemia/infarction as documented in our case. While the acute changes and resolution of hepatic parenchymal disease in HELLP have been reported with magnetic resonance imaging (10), CT is generally more easily available and less costly. In our hospital, abdominal MR is 1.5 times as costly as a contrasted abdominal CT scan.

Acute or delayed rupture of the hepatic subcapsular hematoma is a potentially fatal complication of HELLP Syndrome that can be detected by CT scan (7-9,11-14). These patients may present with severe RUQ pain, shoulder pain, shock, ascites or pleural effusion. Detection of subcapsular hematoma is important due to the high mortality of rupture reported by Henry et al (15) (96 percent with conservative therapy and 33 percent with surgical management.)

Ligation of the hepatic artery can control hemorrhage; however, there is an associated risk of further hepatic compromise. Recently, embolization of active hepatic arterial hemorrhage has been advocated as an alternate method of therapy (6,8,16).

In our case, no definite subcapsular component was identified. Thus, the small amount of free intraperitoneal fluid demonstrated was felt to represent ascites and a conservative approach was undertaken. Our patient had a second CT (Figures 2a,2b) one month after the initial CT to evaluate for persisting hepatic lesion and assess the risk of delayed rupture of hepatic subcapsular hematoma. The proteinuria and liver enzyme abnormalities our patient was experiencing soon resolved.

Conclusion

In summary, HELLP syndrome is an uncommon syndrome associated with preeclampsia-eclampsia. Computed tomography is useful in determining the extent of hepatic involvement and helpful in planning management strategies.

We found that follow-up imaging with CT was useful and cost effective to document resolution of hepatic abnormalities and to dismiss concern for delayed capsular rupture.

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Gastroesophageal reflux disease in children older than two years of age

NASER TOLAYMAT, M.D.
Assistant Professor of Pediatrics, Department of Pediatrics, Robert C. Byrd Health Sciences Center of West Virginia University, Charleston Division

DAWN M. CHAPMAN
Biology Student, Robert C. Byrd Health Sciences Center of West Virginia Department of Pediatrics, Morgantown

Abstract

Since there are few studies examining gastroesophageal reflux (GER) in healthy children beyond infancy, we report our experiences treating children older than two with this condition. GER was diagnosed by either an abnormal extended intraesophageal pH monitoring (pH study) or presence of histological esophagitis. Thirty-seven patients met the criteria, ages 3 to 19 years (mean 11) and 68% were males. Common symptoms were vomiting, abdominal or chest pain, heartburn and regurgitation. Mean duration of symptoms was 28.7 months, and six patients had severe esophagitis, and one had Barrett's esophagus. Patients with severe esophagitis were older and had strongly positive pH study parameters compared to the rest of patients ($p < 0.05$). All patients were treated with prokinetic and acid reducing agents for 8 to 12 weeks. Sixty-two percent responded to initial course and remained asymptomatic during the follow-up period. Nissen fundoplication was recommended to five patients (13.5% of study population) because of refractory GER. Four of these patients who required surgery had severe esophagitis. In summary, GER in normal older children is a chronic disease with potentially severe complications. All patients should be evaluated by pH study and endoscopic esophageal biopsies, and have careful follow up.

Introduction

Gastroesophageal reflux (GER) is a common disorder in infants. Most studies have focused on infants with GER and only a few studies have evaluated the presentation, diagnosis, and treatment of older children (1).

GER in infants is easy to recognize (regurgitation and vomiting are common presenting symptoms), and most of them become free of symptoms by 12-18 months of age (2,3,4). If GER persists beyond infancy it becomes a chronic disease, and complications may develop such as severe esophagitis (5), esophageal stricture (4), Barrett's esophagus and possible esophageal adenocarcinoma (6-9).

Recognition of GER in older children is important in order to provide adequate treatment and to prevent complications.

Methods

A chart review was conducted of patients who were referred for GER between June 1993 and June 1995. This study included children older than two years of age who were without known risk factors for GER, such as a neurological deficit, chronic lung disease, prior esophageal disease or surgery.

All patients underwent 18-24 hours of intraesophageal pH monitoring (pH study) and upper endoscopy with biopsies. A disposable antimony pH probe was placed in the distal third of the esophagus and position was verified by chest radiograph. Data was analyzed using EsopHgram software (Synectics Medical). A reflux episode is defined as a drop of the intraesophageal pH to < 4.0 for > 20 seconds. Each study was evaluated for (a) the number of reflux episodes per hour and (b) the percent time of intraesophageal pH < 4.0 during the study. Abnormal pH study was defined by (a) the number of reflux/hour > 1.5 or (b) the percent time of pH < 4.0 in the lower esophagus > 4% (10-12).

At least two biopsies were obtained from the distal esophagus, 3-5 cm above the gastroesophageal junction during upper endoscopy. Esophagitis was defined as an increase in intraepithelial eosinophils or neutrophils and/or by basal zone hyperplasia (5,13). Esophagitis was categorized as severe when the esophageal mucosa was ulcerated visually. GER disease was diagnosed by either the presence of histological esophagitis or an abnormal pH study.

All patients were first treated with prokinetic agents (metachlopromide (Reglan®) or cisapride (Propulsid®) and acid reducing agents. Response to therapy was defined as symptom improvement during follow-up.

Statistical analysis

Data were expressed as mean ± SEM. Student's *t* test was used to compare differences between means, and Fisher's exact test was used for categorical data. Probability (p) values of < 0.05 were regarded as significant.

Results

Thirty-seven patients were included in this study. Ages ranged from 3 to 19 years, and the mean age was 11 ± 0.6 year. Of these patients, 25 were males (68%). Duration of follow-up was 2-23 months with a mean of 8.4 ± 0.8 months. Presenting symptoms of the study patients are shown in Table 1, and these symptoms were divided into major symptoms or chief complaints, and minor symptoms.

Vomiting and abdominal pain were the most common symptoms (59% of patients), and were reported as the major symptoms in 43% and 40% respectively. Twenty percent of

Table 1. Presenting symptoms of 37 patients diagnosed with gastroesophageal reflux disease.

Symptoms	Major*	Minor*	Combined*
Vomiting	16 (43%)	6 (16%)	22 (59%)
Abdominal Pain	15 (40%)	7 (19%)	22 (59%)
Chest Pain/Heartburn	8 (22%)	12 (32%)	20 (54%)
Regurgitation	6 (16%)	11 (30%)	17 (46%)
Nausea	2 (5%)	4 (11%)	6 (16%)
Dysphagia	2 (5%)	3 (8%)	5 (13%)
Weight Loss	0	3 (8%)	3 (8%)
"Water brash"†	1 (2.5%)	0	1 (2.5%)
Anemia	0	1 (2.5%)	1 (2.5%)

**Many patients had more than one complaint.*

†Sudden, excessive saliva flow secondary to lower esophageal acidification.

Table 2. Comparison of Group 1 (patients with severe/ulcerative esophagitis) and Group 2 (the rest of the study population). Values are mean ± SEM.

	Group 1	Group 2	P-value
Number of patients	6	31	
Age of Patients	14.5 ± 1.3	10.2 ± 0.6	0.005
pH study: #ref/hr.	4.14 ± 0.7	2.4 ± 0.4	0.034
% Time	23.8 ± 6	7.5 ± 1.1	0.022
Fundoplication	4	1	0.001

patients reported abdominal pain as the only presenting symptom. Chest pain/heartburn and regurgitation were also frequent symptoms of 54% and 46% of children respectively, but were the major symptoms in less than 25% of the patients.

Other symptoms included nausea, dysphagia, and weight loss. One patient had significant anemia with hemoglobin of 8.6 g/dl, and one patient had a rare presentation of "water brash" and sudden choking. Water brash is a sudden filling of the mouth with saliva, probably as a result of lower esophageal acidification (14).

The mean duration of symptoms was 28.7 ± 5.7 months (range one month - 13 years). Sixteen patients had symptoms for less than one year, 14 patients had symptoms for one to five years and seven patients had symptoms for more than five years.

In this group of 37 patients with GER, 26 patients (71%) had both abnormal pH study and esophagitis, six patients (16%) had esophagitis and normal pH study and five patients (13%) had abnormal pH study and no esophagitis. The mean number of reflux/hour was 3.2 ± 0.4. The mean percent time of esophageal pH < 4 was 12.8 ± 2.1%. Esophagitis ranged from mild to severe (ulcerated), but none of the five patients who reported dysphagia had severe esophagitis.

Patients were divided into two groups based on the degree of the esophagitis, Group 1 consists of six patients with severe esophagitis, and Group 2 consists of the rest of the study population. Comparison of these two groups is summarized in Table 2, which shows there was a statistically significant difference in age and pH study parameters between the groups, ($p < 0.05$). Patients in Group 1 were older and had strongly positive pH study parameters. One 14-year-old patient with ulcerated esophagitis had Barrett's esophagus (BE). His pH study revealed severe GER (number of reflux/hour was 3.6 and percent time was 38.6%). Of the 26 patients (70%) who underwent barium upper gastrointestinal study, only five patients (19%) revealed GER. None of these studies revealed severe/ulcerated esophagitis, stricture, or any other esophageal abnormality.

All patients were treated with a prokinetic agent (metachlopromide or cisapride) and an acid reducing agent for 8-12 weeks. Twenty-three patients (62%) responded to initial treatment with improvement of their symptoms, and they remained asymptomatic during the follow-up period. Patients who responded to the first course of treatment were compared to those who did not. There were no significant differences ($p > 0.05$) between these two groups in age, pH study parameters or the presence of esophagitis.

Patients who failed the initial course of therapy and those who relapsed later were treated again for longer periods. Only two patients out of six with severe esophagitis (Group 1, Table 2) responded to treatment and remained asymptomatic during the follow-up period. The remaining four patients became refractory to treatment, and were referred for fundoplication. In comparison, 21 patients (68%) from Group 2 responded to the initial course of treatment, and remained asymptomatic. The other 10 patients relapsed and were treated again for longer periods. Only one patient from Group 2 became refractory and was referred for fundoplication.

Nissen fundoplication was recommended to five patients (13.5%), and three patients underwent the surgery without complications or relapse of their symptoms during the follow-up period of 7-19 months. The only patient with Barrett's esophagus had a repeat pH study and endoscopy

eight months after fundoplication. His post-fundoplication pH study and esophageal biopsies were normal with regression of his Barrett's esophagus and his ulcerative esophagitis.

Of the remaining two patients referred for surgery, one patient is under evaluation and the other patient (with ulcerative esophagitis and anemia) refused surgery and is lost to the follow-up.

Discussion

GER is a relatively common disorder in infancy which generally has a good outcome. Disappearance of symptoms occurs in the majority within the first two years of life (2,3,4). In some infants, GER may persist through childhood and eventually to adulthood. If this occurs, complications may arise such as severe esophagitis (5), esophageal stricture (4), Barrett's esophagus (6,7) and rarely esophageal adenocarcinoma (8,9).

Previous studies have shown that children with neurological handicap, previous esophageal surgery for esophageal atresia or achalasia, or chronic lung disease are at high risk to develop GER disease. Our study, however, focused on children older than two years of age without such risk factors for GER. The most common presenting symptom of GER in infancy is vomiting (85-95%) (15), while the most common symptom in adults is heartburn (40%) followed by regurgitation and epigastric pain (16). In our study, 60% of the patients with GER reported vomiting which compares to a previous study (1). Since vomiting is less frequent in older children as compared to infants, GER should still be considered even if vomiting is absence if other symptoms are suggestive of GER (Table 1).

Abdominal pain was a common complaint among about 60% of our patient population. Frequently, the pain was accompanied by other symptom(s) suggestive of GER (regurgitation or heartburn), but a detailed history is necessary because the child may not report such symptoms voluntarily. Even with such an approach, we found that 20% of our patients reported chronic abdominal pain as the only symptom. These patients will be difficult to differentiate from other children with functional abdominal pain unless a high index of suspicion for GER is maintained and they undergo further evaluations.

Extended intraesophageal pH monitoring (pH study) is an accepted method, and even considered the gold standard to diagnose GER (1,17). We used a positive pH study, or the presence of esophagitis to diagnose GER disease, because as previously reported, 29% of adult patients with esophagitis had normal pH studies (18). Our study showed both an abnormal pH study and the presence of esophagitis had equal importance in the diagnosis of GER disease with a sensitivity of approximately 85% for each. This is similar to previous reports in the pediatric population (60-80%) (5,13).

Presenting symptoms did not predict the presence of severe esophagitis, reinforcing the importance of endoscopy and histological examination of esophageal biopsies. Children with ulcerative esophagitis tend to be older (14.5 years vs. 10.2 years), have strongly positive pH study parameters and are more likely to fail medical treatment and require surgery.

Barium esophagogram is useful in eliminating other diagnoses such as a congenital or acquired structural cause for vomiting, but it has a high false-negative rate in the diagnosis of GER and/or esophagitis compared to a pH study or endoscopy with esophageal biopsies. In a previous study, GER was diagnosed by barium study in 50% of cases, and in 6.7% of the cases, esophagitis only was diagnosed (19).

These observations suggest that older children suspected to have GER should be investigated thoroughly. Evaluation should include a pH study and an endoscopic exam with esophageal biopsies to confirm the presence of esophagitis and to evaluate for possible complications such as severe esophagitis, and rarely BE and esophageal adenocarcinoma. Barrett's esophagus is a metaplastic change of squamous esophageal epithelium to specialized columnar mucosa as a result of longstanding, severe gastroesophageal reflux (20). BE has been recognized with increasing frequency in children with GER with the increased use of endoscopy.

The prevalence of BE in adults and children with endoscopic esophagitis is 12-13% (7,21). BE may be complicated by the development of adenocarcinoma, which is found in about 10% of adult cases at diagnosis (9). Adenocarcinoma of the esophagus in BE does occur in children (8) even though it is rare. Regression of BE frequently occurs when reflux is eliminated (22), such as in our patient's case.

Summary

This study demonstrates that GER in healthy older children can be a chronic, sometimes relapsing disease with a less favorable outcome compared to GER in normal infants. Extended intraesophageal pH monitoring (pH study) and endoscopy with esophageal biopsies should be performed when there is suspicion of GER in healthy children.

Children with documented GER will need careful monitoring and clinical follow-up. Persistent GER, especially with persistent esophagitis, should be considered as an indication for antireflux surgery to prevent severe, late complications.

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Therapeutic use of colony stimulating factors for established neutropenic fever

SUZANNE M. WALTON, PHARM.D., BCPS
Clinical Pharmacist Specialist in Oncology, Charleston Area Medical Center, Charleston

Abstract

The hematopoietic growth factors granulocyte colony-stimulating factor (G-CSF) and granulocyte-macrophage colony-stimulating factor (GM-CSF) are approved only for prophylaxis of infectious complications secondary to the use of chemotherapy, yet both are often used off-label therapeutically in conjunction with antibiotics following the onset of neutropenic fever. Several recent trials have evaluated the use of CSFs as adjuncts to antibiotic therapy for the management of patients presenting with neutropenic fever following chemotherapy administration. Statistically significant reductions in days of neutropenia by one or two days were observed in some trials but the clinical significance of these results is uncertain. Most trials demonstrated no reductions in duration of hospitalization, number of days of fever, or mortality. Given the current lack of data supporting the use of CSFs as adjuncts to antibiotic therapy in patients presenting with neutropenic fever, and given the high cost of these drugs, their use for this indication is not recommended at this time.

Introduction

Historically, neutropenia has been regarded as an unalterable consequence of cancer chemotherapy, whose depth and duration are the primary risk factors for the development of infection (1).

The hematopoietic growth factors granulocyte colony-stimulating factor (G-CSF) and granulocyte-macrophage colony-stimulating factor (GM-CSF) can substantially increase the number, and perhaps function, of granulocytes (2). G-CSF is available commercially in the U.S. as filgrastim (Neupogen®, Amgen, Thousand Oaks, CA) and GM-CSF as sargramostim (Leukine®, Immunex Corp., Seattle, WA). These agents are approved only for prophylaxis of infectious complications secondary to the use of chemotherapy, yet both are often used off-label therapeutically in conjunction with antibiotics following the onset of neutropenic fever.

Treatment only for infection could potentially reduce the number of patients exposed to growth factor and decrease the costs of treatment. The rationale for this approach is based on the premise that CSF-treated patients should have a shorter duration of neutropenia, thus a reduced rate of infectious morbidity and mortality.

This article describes several recent trials which have evaluated the use of CSFs as adjuncts to antibiotic therapy for the managment of patients presenting with neutropenic fever following chemotherapy.

Clinical trials of CSFs

The largest published trial of CSFs was a randomized, double-blind, placebo-controlled trial of 218 patients with fever (temperatures > 38.2°C) and neutropenia (neutrophil count < 1.0 x 10^9/L), who were not in shock, following chemotherapy.

In this study, patients were randomly assigned to receive filgrastim (12 µg/kg of body weight per day as a continuous intravenous infusion) (n = 109) or placebo (n = 107) beginning within 12 hours of empiric therapy with piperacillin and tobramycin. Patients remained on study until the neutrophil count was greater than 0.5 x 10^9/L and until four afebrile days (temperature < 37.5°C) had elapsed.

Compared to placebo, filgrastim reduced the median number of days of neutropenia (neutrophil count < 0.5 x 10^9/L) from 4.0 days to 3.0 days (p = 0.005) and the time to resolution of febrile neutropenia from 6.0 days to 5.0 days (p = 0.01). The frequency of alternate antibiotic use was similar in both groups (46% in the G-CSF group vs. 41% in the placebo group; p = 0.48). The median days of fever was 3.0 for both groups (p = 0.12) and the number of days of hospitalization was 8.0 for both groups (p = 0.09). There were no differences in complications or survival between the two groups (3).

Mayordomo et al (4) conducted an open-label randomized trial of 121 patients with fevers > 38°C and neutropenia (absolute neutrophil count [ANC] < 500/mm^3) induced by standard dose chemotherapy. Patients received either G-CSF (5 µg/kg body weight) (n = 39), or placebo (n = 43) beginning within eight hours after neutropenic fever was diagnosed. Treatment was continued for at least five days (seven days with clinically or microbiologically documented infections) or until the ANC > 1000/mm^3 for two days. Patients were required to be in the hospital for a minimum of five days per institution policy.

The median duration of neutropenia < 500/mm^3 was 2.0 days in the G-CSF and GM-CSF groups and 3.0 days in the placebo group (p < 0.001). The median days of fever was not significantly

different in the two groups. The median time on G-CSF or GM-CSF was 4.0 days. The median days of hospitalization was 5.0 days in both the G-CSF and GM-CSF groups and seven days in the placebo group ($p < 0.001$). A statistically insignificant trend toward lower cost was observed with the treatment groups vs. the placebo group due to shorter hospital stay of patients receiving G-CSF or GM-CSF.

A randomized, double-blind, placebo-controlled trial of 134 patients with chemotherapy-related fever (temperatures > 38.5°C once or > 38° C twice in a 12-hour period) and neutropenia (neutrophil count < 0.5 x 10^9/L) was conducted by Vellenga et al (5). Patients were randomly assigned to receive GM-CSF (5 µg/kg of body weight per day) (n = 65) or placebo (n = 69) beginning simultaneously with empiric antibiotic therapy for a minimum of four days and a maximum of 14 days. Patients stayed with the study until the neutrophil count was greater than 1.0 x 10^9/L and until two afebrile days (temperature < 37.5°C) had elapsed. Quality of life and cost-effectiveness analyses were also performed.

There were no significant differences among groups with regard to the median number of days the neutrophil count was less than 0.5 x 10^9/L (3.0 days in the GM-CSF group vs. 4.0 days in the placebo group). The median days of fever was 3.0 for both groups. The median number of days of hospitalization was 6.0 in the GM-CSF group and 7.0 in the placebo group, a difference which was not significant. Mortality was the same in both groups. Quality-of-life scores in 90 patients demonstrated significant differences in favor of the placebo group. The median of all costs was $4,140 in the GM-CSF group and $3,590 in the placebo group ($p < 0.05$) due primarily to the cost of the GM-CSF.

Biesma et al enrolled 30 patients with chemotherapy-related leukopenia (white blood cells less than 1.0 x 10^9/L) and fevers ≥ 38.5°C in a double-blind randomized trial (6). Patients were randomized to receive GM-CSF (2.8 µg/kg of body weight per day via continuous intravenous infusion) (n=15) or placebo (n=15) beginning simultaneously with antibiotic therapy and continuing for seven days. Antibiotics were discontinued when the temperature was normal for two days.

After two days of treatment, patients who had received standard dose chemotherapy had a higher percentage increase in neutrophil count compared with day 0 in the GM-CSF group vs. the placebo group ($p < 0.05$). This difference, however, disappeared after seven days of treatment. Differences in absolute leucocyte and neutrophil counts between the two groups were not statistically significant. The median number of days of fever following initiation of treatment was 1.5 in both treatment groups. No significant differences in duration of antibiotic administration were observed between groups.

In a double-blind study of 58 episodes of fever > 38.0°C and neutropenia (absolute neutrophil count < 200 x 10^6/L), children received either GM-CSF (5.0 µg/kg of body weight per day intravenously as a four-hour infusion) (n = 28) or placebo (n = 30) combined with antimicrobial therapy. Therapy was continued until patients were afebrile (temperature < 37.5°C), C-reactive protein level returned to baseline, and the absolute neutrophil count was > 500 x 10^6/L for at least two days.

The median number of days to resolution of neutropenia was 4.5 days in the GM-CSF group and 6.0 days in the placebo group ($p < 0.05$). A significant difference was also demonstrated in the median number of days of hospitalization (9 days in the GM-CSF group and 10 days in the placebo group $p < 0.05$) and in the number of days on antibiotics (7.0 days for the GM-CSF group and 8.5 for the placebo group; $p < 0.05$). The mean number of days of fever ≥ 38.0°C) was 2.1 days in the GM-CSF group and 2.3 days in the placebo group ($p=0.14$). There were no fatalities in either group (7).

Discussion

Prophylactic use of hematopoietic growth factors after chemotherapy administration has been shown to reduce the incidence of neutropenia and fever (8). Widespread use of these agents has occurred for a variety of applications and even greater use is anticipated in the future.

Although an early trial in patients receiving G-CSF after combination chemotherapy for small-cell lung cancer demonstrated a reduction in severity and duration of neutropenia, the incidence of febrile neutropenia, and the number of days of hospitalization and intravenous antibiotic use, uncertainties exist as to the cost-effective use of these agents even in the setting of prophylaxis (8). Certainly, no study thus far has convincingly demonstrated reductions in duration of hospitalization or in cost for the use of colony stimulating factors when administered therapeutically (i.e., after the onset of neutropenia and fever).

While statistically significant reductions in days of neutropenia were observed in both the Mayer and Mayordomo trials, it is important to ask whether these results are clinically meaningful. A reduction in duration of neutropenia of one day (from 4.0 days to 3.0 days in the Maher trial and from 3.0 days to 2.0 days in the Mayordomo trial) through adjunctive use of a colony stimulating factor is unlikely to be regarded as important by many clinicians. The practical benefit of shortening an already brief period of neutropenia with costly agents is questionnable. The use of growth factors failed to impact the number of febrile days. Periods of fever were brief in both treatment and placebo groups in all trials.

Hospitalization duration was unaffected by the use of colony stimulating factors in most of the trials. The importance of reducing hospital stays by two days in the Mayordomo trial is worth examining. As a recent editorial points out (9), the requirement in that study that patients remain hospitalized for five

days is not a universal one. In many institutions, patients are discharged once the ANC is greater than 500 and they are afebrile. Identification of low-risk patients for early discharge on oral antibiotic regimens would probably obviate the slight advantage in hospitalization duration observed in this trial and be more cost effective in all likelihood (9).

In general, it is unclear whether supplemental exogenous CSF would have any additional benefit over antibiotics alone when utilized for this indication. Endogenous colony-stimulating factor serum levels have been noted to be detectable in patients who were febrile, neutropenic, or septic (10).

In the Vellenga trial, serum cytokine levels were measured at presentation and at 24 hours after initiation of treatment with antibiotics and GM-CSF. At presentation, high levels of IL-6 and G-CSF were observed, especially in patients with bacteremia. At the 24-hour measurement, no change in the cytokine profile was observed due to the administration of GM-CSF, although significantly higher levels of GM-CSF were measured in the GM-CSF-treated group. This study failed to show any significant differences in median days of neutropenia less than 0.5 x 10^9/L, days of fever, or duration of hospitalization, and there was no difference in mortality rate observed between groups.

Differences in type of CSF (i.e., G-CSF vs. GM-CSF) used in the trials as well as the dosages and routes of administration precludes any direct comparison between agents. It is also difficult to compare trials due to variations in entry criteria of definitions of both neutropenia and fever, as well as the fact that the endpoints of some trials also differed significantly. In addition, comparisons are difficult because of differences in antibiotic policies between the various institutions as well as any requirements for minimum lengths of admission.

The American Society of Clinical Oncology, in its recent release of updated guidelines for the use of hematopoietic growth factors, failed to change its former recommendation against the use of these agents as routine adjuncts to antibiotic therapy in patients with febrile neutropenia. Certain febrile, neutropenic patients may have prognostic factors that are predictive of clinical deterioration (e.g., pneumonia, hypotension, multi-organ dysfunction [sepsis syndrome], or fungal infection) and use of CSFs may be warranted, although there are no prospective statistics to confirm this (11,12).

In recent years, it has become clear that not all neutropenic cancer patients are at the same level of risk for developing severe infections or life-threatening complications during neutropenia. These patients generally can be divided into "low-risk" versus "high-risk" categories based on the duration of their neutropenia. Generally, low-risk patients have a duration of neutropenia less than seven days and tend to do well regardless of therapeutic approach. High-risk patients, on the other hand, remain neutropenic for more than 7-10 days, are subject to secondary infections, and frequently require more than one antimicrobial agent and empiric antifungal therapy (13). Differentiating between these two subsets is becoming an important factor in deciding what interventions might be used in the management of neutropenic cancer patients, including possibly the use of colony stimulating factors (14,15).

Given the current lack of data supporting the use of CSFs in conjunction with antibiotic therapy in patients presenting with neutropenic fever and given the high cost of these drugs, their use for this indication seems an impractical and expensive approach to patient management at this time.

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Compared contralateral application of topical nitroglycerin on Purpura Fulminans

JOSE IRAZUZTA, M.D.
Director of Critical Care Medicine, Division of Critical Care Medicine, Children's Medical Center, Dayton, Ohio; Associate Professor of Pediatrics, University of Cincinnati, Cincinnati; Former Associate Professor of Pediatrics, Robert C. Byrd Health Sciences Center of West Virginia University, Charleston Division; and Medical Director, Pediatric ICU, Women and Children's Hospital, Charleston

JOE JARRELL, M.D.
Former PGY4 Medicine/Pediatrics, Women and Children's Hospital, Charleston

AUGUSTO PORTILLO, M.D.
Plastic and Reconstructive Surgeon, Department of Surgery, Charleston Area Medical Center, Charleston

KARL L. KLAPPROTH, M.D.
Attending Pathologist, Department of Pathology, Charleston Area Medical Center, Charleston

Abstract

In cases of purpura fulminans (PF), various treatments have been used to prevent the cutaneous involvement and extensive skin necrosis that can be both disfiguring and debilitating. In this article, we present a case where improvement in the progression of purpuric areas was accomplished by topical administration of nitroglycerin (TNG), as evidenced by comparison with symmetrical contralateral areas not so treated.

Case report

A 16-month-old female developed diffuse purple spots a few hours before admission. In the Emergency Room, shock, petechiae and purpura of all four extremities, the buttocks, and the face were noted.

After fluid resuscitation, antibiotic therapy, and dexamethasone, she was transferred to the pediatric intensive care unit (PICU). Two hours later, she was intubated, had a central line, and was receiving frequent Hespan® infusions, dopamine and epinephrine. The cardiac ejection fraction measured by the single plane ellipse method was 11 percent. Her platelet count was 28,000. Twenty percent of the body surface area was purpuric, mainly involving symmetrical areas on the upper and lower extremities.

As soon as cardiorespiratory stabilization was achieved, the areas of purpura were considered for treatment. After discussion with the parents and the chairperson of the Institutional Review Board of Charleston Area Medical Center/ West Virginia University, informed consent was obtained to apply TNG to the purpuric areas on one side of the body. An individual who had not seen the patient chose the left side.

Purpuric areas of the left arm and leg were treated with a thin film of TNG ointment (Nitro-Bid®) every 8 hours for 11 days, which was about 1 gram per application. This treatment was initiated within eight hours of admission. The right side did not receive TNG and after the 7th day was kept covered with petroleum jelly and gauze. Cooling blankets were not used on her so there would be no further vasoconstriction. Fresh frozen plasma was not given because of its increased procoagulant effects and a lack of Protein C content (1).

Catecholamine support for her cardiac failure was soon changed to a phosphodiesterase C inhibitor (amrinone) to avoid increases in sympathetic tone. The low platelet count was corrected when the level dropped below 15,000 or she had signs of active oozing. Later, fentanyl and bupivacaine were infused through an epidural catheter to provide local analgesia.

Two days after admission, the level of Protein C was 14 percent (normal 70 to 140), Protein S was 10 percent (normal 62 to 115), and Antithrombin III was 34 percent (normal 78 to 117).

The areas where TNG was applied became violet-red, and remained dissimilar in color to the contralateral areas. Within a week, the contralateral areas had evolved to a hard consistency, while the areas treated with TNG remained soft.

On day 28, this patient went to the operating room. Prior to debridement, punch biopsies were obtained from symmetrical areas on the upper and lower extremities for comparison. The plastic surgeon evaluated the lesions as requiring partial thickness grafts for the areas on the TNG side and full thickness grafts for the areas on the untreated side. He did not initially graft on the side treated with TNG because he thought it would not be needed, but later it did prove necessary. Her right knee (untreated side) required two more grafts than the left knee. Her methemoglobin level during TNG application remained less than 3 percent.

We did not find a cause for her sepsis; a positive nasal swab for adenovirus was interpreted as a concomitant infection. The presence of osteomyelitis in the left arm was noticed on day 32. Blood cultures were positive for Pseudomonas the previous week. She was receiving antibiotic coverage and no bacteria were found on bone marrow

aspiration. She survived after a protracted course of debridements and skin grafts, and required only the amputation of the distal phalanx of the middle finger on her left hand.

The pathologist evaluating the biopsies was not initially informed about the prior treatment. He reported a difference between the TNG treated and untreated sides of the punch biopsies. The untreated side showed complete loss of epidermal nuclei with severe ischemic changes of the epidermis. The dermis on this untreated side had moderate to mild vascular congestion and there was marked inflammation of the subcutaneous fat with vasculitis.

On the TNG treated side, the epidermis showed moderate preservation of nuclei and a moderate degree of ischemic change. The dermis had increased congestion of dermal vessels when compared with the contralateral side. There was focal to no inflammation of the subcutaneous fat and an absence of vasculitis on this treated side.

Discussion

Purpura fulminans describes a condition that either follows a benign infection with the development of disseminated intravascular coagulation (DIC), hypotension, and purpura of distal areas (2), or more commonly, presents with septic shock, DIC, and secondary purpura (3). We did not have an initial positive blood culture, but the presentation was typical for septic shock. The presence of an adenoviral infection was documented; the association of viral infections prior to epidemics of PF has been reported (4).

The pathophysiology of PF is presumed to involve endotoxemia, vasculitis, and a localized hypercoagulable state (5) with thrombosis of venules and capillaries when associated with sepsis. A greater decrease of Protein C, S, and Antithrombin III (anticoagulants) in relation to procoagulant factors such as PT and PTT may produce hypercoagulability at the level of the capillaries.

There has been documentation of an association of induced decrease in Protein C (a naturally occurring anticoagulant) and the severity of PF (1). While the future availability of Protein C concentrate raises hopes of treating the coagulation imblance of PF, currently treatment is focused on the purpuric areas once they have appeared. Several regimens, including heparinization (6), infusion of dextran (7), hyperbaric oxygen therapy (8), sympathetic block (9), and TNG (10) have been described. The scarcity of the cases and the lack of an adequate animal model have prevented rigorous controlled trials of these treatments.

In our patient, TNG improved the evolution of the treated tissues compared to the contralateral side, evidenced by differences in coloration, degree of induration, depth of involvement, and reduction of damage in affected areas assessed by microscopic examination. These findings may correlate with the clinical evolution of her lower extremities where she required additional grafts on the right untreated side.

While experience with TNG in the treatment of PF is still quite limited, our experience suggests that this treatment holds some promise in reducing the amount of gangrenous progression often found with this condition. Further work documenting efficacy, the optimal time for beginning treatments, as well as minimal effective doses should be undertaken. We are not aware of any association between the use of TNG in PF and osteomyelitis, and would welcome any information that others may have experienced.

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West Virginia Chapter — American College of Surgeons

Annual Spring Meeting

April 30 — May 2, 1998

The Greenbrier®

Guest speakers:

R. Scott Jones, M.D., F.A.C.S.
Harvey Bender, M.D., F.A.C.S.
Ronald L. Nichols, M.D., F.A.C.S.
Ernest Borden, M.D., F.A.C.S.

Speakers from the Southwestern Pennsylvania Chapter, the West Virginia Chapter and residents from WV training programs will complete the program. A golf tournament and reception will be Friday. There will be a $100 registration fee and 10.5 CME hours are available. For more information, contact Sharon Bartholomew at (304) 598-2802. For room reservations, contact The Greenbrier at (800) 624-6070.

While you're looking out for your patients, who's looking out for you?

The American Medical Association (AMA), in partnership with state, county, and specialty medical societies, works to assure America's patients receive the world's highest level of quality care.

- Speaking out for patients and physicians with a single, powerful voice.
- Continuously advancing the art and science of medicine.
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As a member of the AMA, you can add strength and credibility to our ongoing efforts to confront today's most critical health care issues.

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Give Power to Your Voice.
Join the American Medical Association today.

American Medical Association
Physicians dedicated to the health of America

Dr. Sporck named to Publication Committee

Sporck

F. Thomas Sporck, M.D., F.A.C.S., a Charleston otolaryngologist and prominent member of the WVSMA, has been named an associate editor of the *West Virginia Medical Journal* and a member of the WVSMA Publication Committee. In his new role, Dr. Sporck will work with the other editors to review, edit and qualify articles submitted for publication. Members of the Publication Committee determine the *Journal's* general content and format, and contribute to its editorial content.

Dr. Sporck received his M.D. degree in 1972 from the West Virginia University School of Medicine, where he also completed a surgery internship and residency in otolaryngology. In addition to his residency, Dr. Sporck completed fellowships in otolaryngic pathology at the Armed Forces Institute of Pathology, in cleft lip and palate at the Univerity of Iowa, and in facial plastic and reconstructive surgery with Dr. Walter Berman in Beverly Hills, Calif. He served in the U.S. Army Reserves from 1973-81.

Since July 1, 1980, Dr. Sporck has been in private practice with Ear, Nose & Throat Associates of Charleston, Inc. He is board certified by the American Board of Otolaryngology and is on staff at Saint Francis Hospital, where he is past chief of surgery and chairman of the Ethics Committee. In addition, Dr. Sporck is on the staff at Charleston Area Medical Center and serves on the consulting staff at Thomas Memorial Hospital and Ruby Memorial Hospital in Morgantown.

Dr. Sporck is secretary-treasurer of the West Virginia Academy of Otolaryngology, of which he is also a past president. He is a fellow and serves as chairman of the Legislative Representative Committee of the American Academy of Otolaryngology - Head and Neck Surgery Inc. A fellow of the American College of Surgeons, Dr. Sporck is also very active in the AMA and the WVSMA. He is chairman of the WVSMA's Legislative Committee, and is a member of WVSMA's Long-Range Planning Committee and the Insurance Committee. In addition, he formerly served on the board of directors for WESPAC.

In 1995, Dr. Sporck served on the Governor's Medicaid Crisis Panel and during his career he has given testimony to the members of the West Virginia Legislature on medical malpractice, the dangers of smokeless tobacco and other tobacco issues, and the need to strengthen laws regarding teenager drivers. A clinical professor of otolaryngology at the WVU School of Medicine, Dr. Sporck has often spoken on television and in schools in favor of the *"Through With Chew"* program aimed at eliminating the use of smokeless tobacco products.

WVAAFP's Annual Scientific Assembly set for Charleston

May 1-3 will be the dates for this year's Annual Scientific Assembly of the West Virginia Chapter of the American Academy of Family Physicians, which will take place in Charleston at the Charleston House - Holiday Inn. In addition, a pre-conference seminar entitled *"Ob/Gyn Update,* as well as three board and committee meetings are planned for Thursday evening, April 30.

This conference will feature a variety of topics of interest to family physicians and other health care professionals. It has been reviewed and is acceptable for 22.25 prescribed hours by the American Academy of Family Physicians.

The first session is scheduled to begin at 8:15 a.m. on Friday, May 1 after remarks by Linda M. Savory, M.D., president-elect of the WVAAFP who is also chair of this year's program, and a welcome by Hovah Underwood, the first lady of West Virginia. The lectures for this session will include *"Antibiotic Resistance," "Treatment of Depression in Patients Without Medical Illness," "Emerging Trends in Type II Diabetes," "Reducing Coronary Events,"* and *"Women and Heart Disease."* Four other scientific sessions, exhibits, as well as a number of business and social events, including an alumni party with a 50s theme, are some of the other highlights set for this year's meeting.

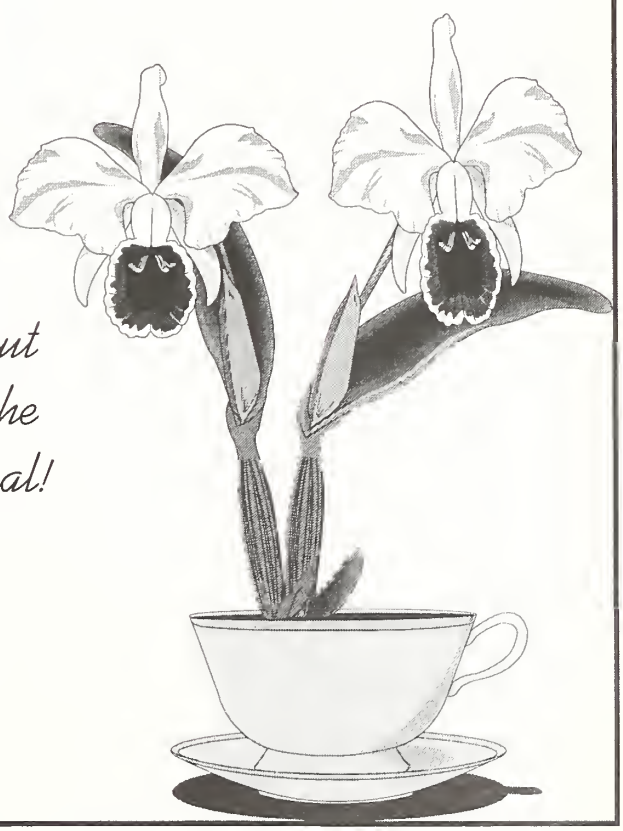
To register or obtain more information, please contact the WVAAFP at 776-7710 or by fax 776-5153.

Correction

In the feature article about Dr. Ralph Simms in the last issue, we apologize for stating that Dr. Simms was nominated for the WVSMA's Rural Physician of the Year Award by Thelma Wilson, executive secretary of the Raleigh County Medical Society. He was nominated by the members of the Raleigh County Medical Society.

August will be here before you know it...
so make plans NOW to attend the

131st Annual Meeting
August 26-29, 1998
The Greenbrier
White Sulphur Springs, WV



Look for more information about the 131st Annual Meeting in the March/April issue of the Journal!

WVSMA

Committed to Excellence

Committed to You

Nidia Henderson joins WVSMA staff

Nidia Henderson, who was the government relations director for West Virginia Behavioral Healthcare Providers Association, is the new director of government relations at the WVSMA.

In her role at the WVSMA, Nidia analyzes legislative issues, acts as a lobbyist at the West Virginia Legislature, assists with the WVSMA Legislative Committee, and writes the copy for *WESGRAM* and the *Legislative Update*. In addition, Nidia serves as the executive secretary to the WVSMA Alliance and WESPAC.

Nidia has a bachelor of arts degree from the University of Pittsburg and a master's degree in management from West Virginia Graduate College. During her career, Nidia has worked in a number of government and community relations positions for United Steelworkers of America, the Association for Retarded Citizens, West Virginia Advocates, Shawnee Hills and West Virginia Behavioral Healthcare Providers.

Nidia served as a member of Governor Caperton's Medicaid Crisis Panel, and currently serves on the board of directors for Highland Hospital and the Coalition for West Virginia's Children.

Orlando site for NRHA Annual Meeting

"Collaborating for Access . . . Capitalizing on Success" is the theme of the National Rural Health Association's 21st Annual National Conference, which will be held from May 13-16 in Orlando, Fla.

The educational program of the conference is tailored to meet the needs of physicians, hospital and clinic administrators, nurses, researchers, policy-makers, educators and state and federal officicals. It features nearly 70 general and concurrent sessions, topical symposia and research paper sessions.

For registration information, contact the NRHA at One West Armour Blvd., Suite 301, Kansas City, Mo. 64111; (816) 756-3140; or by e-mail at mail@nrharural.org.

CAMC, Thomas elect medical staff officers

The medical staffs at the Charleston Area Medical Center in Charleston and Thomas Memorial Hospital in South Charleston recently elected officers for 1998.

Dr. Shawn A. Chillag, a specialist in internal medicine, has been named chief of staff at CAMC; Dr. Paul A. Skaff, an anesthesiologist, is chief of staff-elect; Dr. Frank C. Lucente, a trauma surgeon, will serve as secretary/treasurer, as well as vice chief of surgery. In addition, all of the individual departments elected officers including Dr. Roberto Kusminsky as chief of surgery; and Dr. Gregory Stonestreet, chief of family practice; and Dr. Mely Lim, as vice chief of family practice.

At Thomas Memorial, Dr. Bruce Hoak, will serve as president of the medical staff; Dr. Kishore Challa, as president-elect; Dr. David Abramowitz, as secretary-treasurer; Dr. David Soulsby, chairman of the Dept. of Surgery; Dr. Muhib Tarakji, representative for the Dept. of Surgery; Dr. Duane Berry, chairman of the Dept. of Family Practice and Medicine; and Dr. Jose Canario, representative for the Dept. of Family Practice and Medicine.

Spring meeting for ophthalmologists set for April 23-26

The West Virginia Academy of Ophthalmology's 51st Annual National Spring Meeting will take place at The Greenbrier in White Sulphur Springs from April 23-26.

Featured speakers include Robert C. Allen, M.D., glaucoma; Frederick Davidorf, M.D., retina; Michael Brown, practice management; and Terrance O'Brien, M.D., refractive surgery and cataracts. This meeting has been designated by the WV Academy of Ophthalmology for 12 credit hours of Category 1 of the Physician's Recongnition Award of the AMA.

For further details, contact the WV Academy of Ophthalmology at P.O. Box 5008, Charleston, WV 25361; phone (304) 343-5842; fax 344-3130; or e-mail pas10s@aol.com.

Make-A-Wish plans Monte Carlo Night

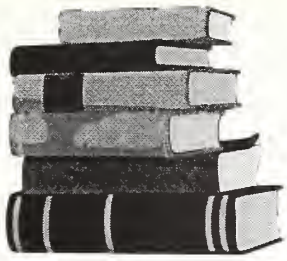
The Make-A-Wish Foundation® of Southern West Virginia is holding a Monte Carlo Night on Saturday, February 28 from 7 p.m. to midnight in Charleston to raise funds for granting the wishes of children with life-threatening illnesses.

This event will be held at the Palladian Room and will feature food by Chef Dan, 15 gambling tables, a D.J. and a dance floor. Tickets are $50 in advance and $65 at the door. There will be an auction of donated prizes to bid on with chips at the end of the night. Dress is black tie optional.

One hundred percent of the proceeds from this fund-raiser will be donated to the Make-A-Wish Foundation® of Southern WV, which currently has 15 wishes in the process of being granted.

To order tickets or obtain more information about Make-A-Wish, phone 1-800-664-WISH or 342-WISH.

Book Review



The Doctor's Asset Protection Kit

By: David B. Mandell, J.D., M.B.A.

Most physicians enjoy well above average incomes and over the years accumulate possessions such as nice homes, furnishings, automobiles, jewelry, retirment accounts, etc. Until I read this book, I was not aware of all of the perils of being perceived as having "deep pockets."

Mandell's book illustrates vividly that there are numerous other legal perils than a disgruntled patient and a malpractice lawsuit. He makes a good argument that insurance, including umbrella policies, are sometimes not sufficient. There may be exclusions or the policy limits may not be adequate. It is sometimes not possible to insure against all the possible ways of being sued since attorneys continue to develop novel approaches to liability. He makes the point that no one can foresee all the things that can go wrong. Therefore, the best strategy is to be adequately protected prior to any unfortunate event.

Statistics indicate that suits are more likely than an automobile accident (4 to 1) or a fire in your home (40 to 1). Mandell states that the overall odds of being involved in legal action are about one in eight. He points out that prior to legal action, it is the usual practice for an attorney to make an economic analysis of the case, especially if there is a contingency fee involved.

The author likens asset protection to a financial fortress. Therefore, asset protection is the major thrust of this book. Among the many examples provided and discussed are limited partnerships, life insurance trusts, corporations, charitable remainder trusts, premarital agreements, foreign trusts, Medicaid planning and limited liability companies.

I would recommend this book for any physician interested in protecting what he/she has accumulated.

Course offered in head and neck anatomy

A four-day postgraduate course entitled *"The Alton D. Brasher Postgraduate Course in Head and Neck Anatomy"* will be conducted at Virginia Commonwealth University School of Medicine from March 9-12.

The primary teaching method is the dissection of the head and neck. Lectures and demonstrations will augment the laboratory work. This course is approved for 44 credit hours by the Academy of General Dentistry.

For more information, contact Dr. Hugo R. Seibel, Dept. of Anatomy, P.O. Box 980709, Virginia Commonwealth University, Richmond, Va., 23298-0709.

Free leaflets discuss otitis media, cochlear implants

The American Academy of Otolaryngology - Head and Neck Surgery has published two brochures to inform patients about inner ear infections and how cochlear implants can help to restore partial hearing to the deaf individuals.

The pamphlet on otitis media is entitled *"Doctor, why does my child's ear ache?"* and the other leaflet is *"Doctor, what is a cochlear implant?*

To obtain free copies, send a self-addressed, stamped envelope with either Coclear Implants or Otitis Media, c/o American Academy of Otolaryngology - Head and Neck Surgery, One Prince St., Alexandria, VA 22314-3357.

Medical Meetings

March

9-12 - The Alton D. Brashear Postgraduate Course in Head and Neck Anatomy, Virginia Commonwealth University, Richmond

13-18 - American Academy of Allergy, Asthma and Immunology, Washington, D.C.

19-23 - American Academy of Orthopaedic Surgeons, New Orleans

20-22 - Clinical Decisions in Urogynecology, sponsored by The Center of Bio-Medical Communication, Inc., NYC

20-22 - Management of the HIV-Infected Patient, sponsored by The Center for Bio-Medical Communicaton, Inc., NYC

27-29 - Clinical Infectious Disease '98: sponsored by The Center for Bio-Medical Communication, Inc., NYC

29-April 1 - American College of Cardiology, Atlanta

30-April 3 - Society of Computed Body Tomography and Magnetic Resonance Annual Meeting, Rancho Mirage, Calif.

April

2-5 - 1998 Annual Session of the American College of Physicians, San Diego

17-21 - American Society of Bariatric Physicians, Las Vegas

22-26 - Critical Care Medicine '98: 12th Annual Review and Update, sponsored by The Center for Bio-Medical Communication, Inc., Washington, D.C.

23-25 - Cardiology Fiesta in San Antonio: Update on Cardiac Diagnostic and Therapeutic Techniques, sponsored by the American College of Cardiology, San Antonio, Texas

CME & Special Events

Camcare Health Education & Research Institute

"Urinary Tract Infections"
Feb. 18, 6 p.m., Joseph DeBord, M.D., Man Appalachian Regional Hospital, Man

"Advances and Diagnosis in Managing COPD"
Feb. 19 (teleconference), Juan M. D'Brot, M.D.

"A.B.B.I.: A New Breast Biopsy Technique"
Feb. 26, noon, Daniel S. Foster, M.D., Pleasant Valley Hospital, Point Pleasant

"Urinary Stress Incontinence"
March 4, 12:30 p.m., Paul H. Fulcher, M.D., Montgomery General Hospital, Montgomery

"Update on Laparoscopic Procedures"
March 4, 6 p.m., James P. Boland, M.D., Fayette County Medical Society, Montgomery

"Developmental Considerations for the Neonate"
March 5 (teleconference), Mary Justice, PT

"A.B.B.I.: A New Breast Biopsy Technique"
March 13, 11:45 a.m., James W. Kessel, M.D., Logan General Hospital, Logan

"New Diagnostic Procedure for Breast Cancer"
March 18, 6 p.m., Edward H. Tiley III, M.D., Man Appalachian Regional Hospital, Man

"Pharmacology and Women's Health Issues"
April 8, Aug. 12 or Oct. 14, 4 p.m., Robert C. Byrd HSC of WVU, Charleston Division

Huntington Medical Community Foundation

"New Concepts in Parkinson's Disease"
Feb. 18, 6 p.m., Carl F. McComas, M.D., Williamson Memorial Hospital Staff, Williamson

"Burns"
Feb. 23, 6 p.m., John A. Hunt, M.D., Three Rivers Medical Center, Louisa, Ky.

"Hepatitis C: An Update"
Feb. 24, 7 p.m., Richard J. Mailloux, M.D., Paul B. Hall Regional Medical Center, Paintsville, Ky.

"TBA"
Feb. 26, noon, Pleasant Valley Hospital, Point Pleasant

"Ethics of Giving/Witholding Tube Feedings"
March 10, noon, Shirley Neitch, M.D., Our Lady of Bellefonte Hospital, Ashland, Ky.

"TBA"
March 11, 6 p.m., Tug Valley Medical Society, Williamson

"TBA"
March 26, noon, Pleasant Valley Hospital, Point Pleasant

Marshall University School of Medicine

"Opening Lecture - 11th Research Day"
April 6, 6 p.m., MU Student Center

"11th Annual Research Day"
April 7, 8 a.m., Radisson Hotel

"Management of Orthostatic Hypotension"
April 21, 8 a.m., Ray L. Watts, M.D.

Robert C. Byrd HSC - Morgantown

"Treating the Nicotine Dependent Patient"
Feb. 18, 1 p.m., Elbert Glover, Ph.D., Fairmont Clinic, Fairmont

"Blood and Marrow Transplant"
March 12, noon, Joseph Lynch, M.D., Broaddus Hospital, Phillipi

"Pets and Pests"
March 12, 7 p.m., Martin Weisse, M.D., Wetzel County Hospital, New Martinsville

"Urology Update"
March 13-14, Lakeview Resort and Conference Center, Morgantown

"Abnormal Liver Function Tests: The Internist's Approach"
March 18, 1 p.m., H. Carlton Palmer, M.D., Wetzel County Hospital, New Martinsville

"Managed Care in the Emergency Room"
March 25, 6 p.m., Ann Chinnis, M.D., Potomac Valley Hospital, Keyser

"Medications For Use During Pregnancy"
March 31, noon, Leo Brancazio, M.D., Camden Clark Memorial Hospital, Parkersburg

Bravo! Ogden

Now and again there comes a time
When I like to express myself in rhyme.

So when I'm sitting alone at home
I often compose a humerous poem.

I'm certain my poems would all be trash
Were they not influenced by Ogden Nash.

His poems were clever, his wit well timed,
And most importantly, always rhymed.

When he couldn't think of a rhyming word,
He'd invent one that no one ever heard.

For instance, to rhyme the word "indescribable"
He might refer to reading the "bibable."

Some of his couplets had perfect timing
While others did not, but always rhyming.

So when I'm faced with a poetic creation
I look to Ogden for inspiration.

And though free verse is not a crime,
My poems, like Ogden's, always rhyme.

Harold Saferstein, M.D.

Poetry

Some poets I know don't take the time
To put their poetry to rhyme.

And then to make things even worse
They call the stuff they write "free verse."

In olden days a poet chose
To rhyme his poem, or call it prose.

Each poet rhymed his words, like me,
And never heard of verse that's "free."

Will Shakespeare did not comment on it,
But rhymed each couplet, verse and sonnet.

So this is what I now propose,
If it doesn't rhyme, let's call it prose.

Harold Saferstein, M.D.

This page of material is submitted and paid for by the Bureau for Public Health.

State names new chief medical examiner

James A. Kaplan, M.D., has been appointed as the new chief medical examiner for the state of West Virginia. Dr. Kaplan succeeds Dr. Irvin M. Sopher who retired earlier this year after serving as medical examiner for the state for nearly 22 years.

Dr. Kaplan comes to West Virginia from New Hampshire where he had served as medical examiner since 1990. Prior to that time, he served as the assistant medical examiner for the state of Maryland.

Dr. Kaplan has a special interest in family violence. His background includes a number of published articles and presentations concerning the recognition and prevention of child, spouse and elder abuse, sudden infant death syndrome and sports-related fatalities.

A 1984 graduate of the Medical University of South Carolina, Dr. Kaplan completed post-graduate pathology studies at the University of Washington in Seattle. In addition, he completed studies in a forensic pathology fellowship at the Bexar County Forensic Science Center in San Antonio, Texas, in 1987.

Dr. Kaplan is a member of the board of editors for the *American Journal of Forensic Medicine and Pathology* and an assistant professor of pathology at Dartmouth Medical School in Hanover, N.H. In November 1996, he spent two weeks in Bosnia at the request of the United Nations-funded International War Crimes Tribunal in the Hague. While there, Dr. Kaplan served with a team of international forensic pathologists investigating war crime deaths and examining victims of mass executions in the former country of Yugoslavia.

In his new role in West Virginia, Dr. Kaplan plans to build on the strong foundation created by Dr. Sopher. In addition, he hopes to increase the awareness and commitment to public health and safety issues relating to the duties of the medical examiner's office.

Workshop being held for those who counsel women about HIV, AIDS

The West Virginia Bureau for Public Health AIDS/STD Program is offering workshops at locations throughout the state about HIV/AIDS counseling for women who plan to have children and who may or may not be at risk for HIV infection.

"HIV Pre- & Post-Test Counseling with Women of Child-bearing Age" is an eight-hour course for health care professionals who work with women. This training is open to physicians, nurse practitioners, nurse midwives, RNs, LPNs, office staff and anyone else involved in HIV testing of women.

In recent years, AIDS experts have emphasized the importance of HIV antibody testing for women who plan to have children. Research has shown that the antiretroviral drug zidovudine, when taken during pregnancy, can reduce the risk of perinatal transmission of HIV from an infected woman to her child. Therefore, it is important for any woman who runs any risk of HIV infection to take an HIV antibody test to determine her serostatus, not only for her own health, but also for the health of any children she may have in the future.

Two of West Virginia's leading HIV/AIDS counselor trainers will be conducting these training sessions. Joy Buck, B.A., M.S.N., R.N., is the Director of Program Development at Shenandoah Valley Medical Center in Martinsburg, and has been providing care for people with HIV in West Virginia since 1983. Greg Moore, BS, is Field Supervisor for the WV Bureau for Public Health STD Program and has been training persons to provide HIV pre- and post-test counseling since 1988.

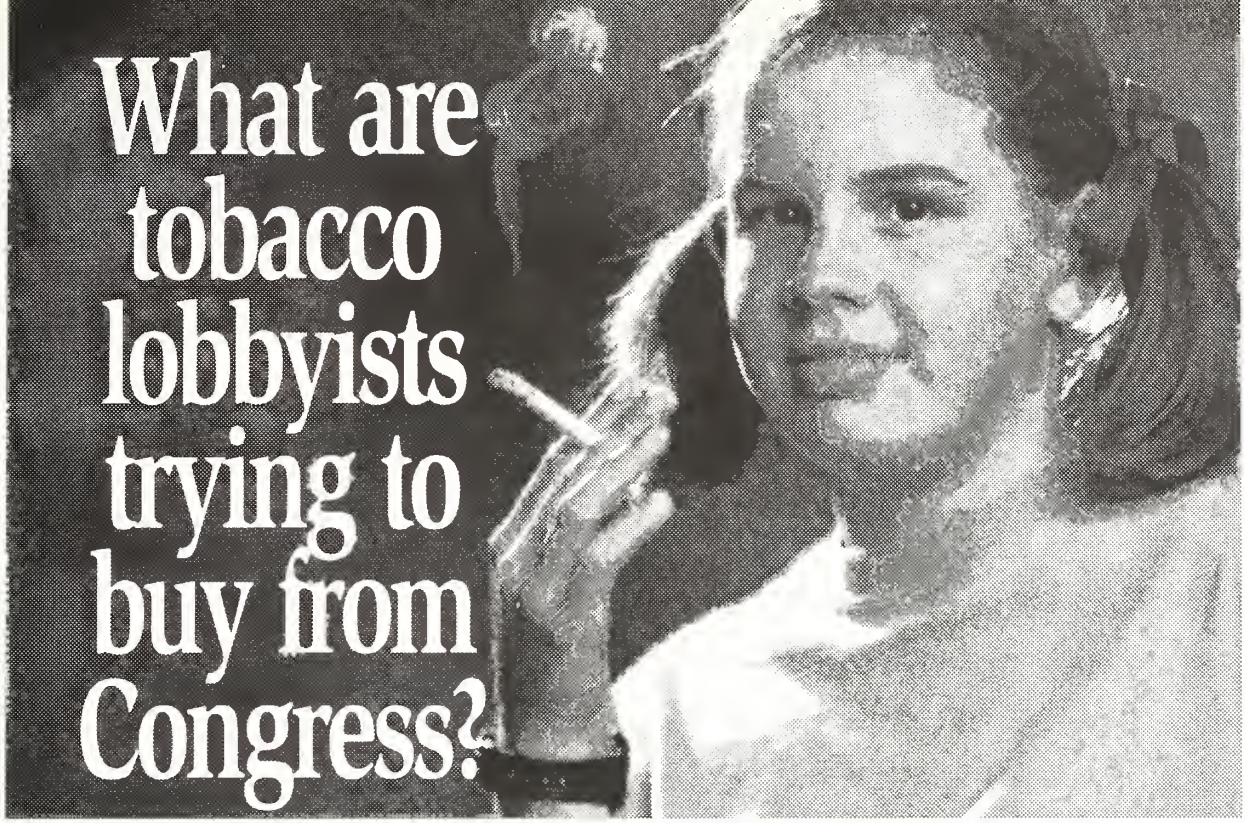
At the end of this eight-hour course, participants will be able to discuss the impact of HIV on the immune system and HIV disease progression, discuss serological testing for HIV antibodies with women of child-bearing age, present appropriate information about reducing perinatal HIV transmission in HIV-positive pregnant women, facilitate HIV prevention counseling for women of child-bearing age, and counsel women considering HIV testing as well as those with HIV seropositive or seronegative test results.

This program has been approved for 9.0 contact hours of continuing education for RNs and LPNs through West Virginia University Hospital.

The first workshops were conducted in Wheeling and Parkersburg in January, and the schedule for the remaining sessions during 1998 is as follows:

Charleston (February 19)
Huntington (February 20)
Beckley (March 2)
Logan (March 3)
Bluefield (March 4)
Camden-On-Gauley (March 21)
Lewisburg (March 24)
Elkins (April 22)
Petersburg (April 23)
Martinsburg (April 24)
Morgantown (May 18)
Clarksburg (May 19)
Fairmont (May 20)
Flatwoods (May 21)

For more information, call Kay McFarland at the West Virginia Bureau for Public Health AIDS/STD Program: 1-800-642-8244.



After decades of lying about addiction and disease, tobacco companies have launched a last-ditch scheme to continue marketing to kids: flood Congress with cash.

During the first half of 1995, tobacco industry contributions to political parties skyrocketed more than 400 percent. Tobacco companies gave more than $1.6 million ($1.5 million to Republicans), becoming the GOP's largest donor by far.

Why the sudden surge? President Clinton and Members of Congress from both parties are backing new limits on tobacco marketing to kids—limits that could save thousands of children from addiction, disease and death. Tobacco companies are desperately trying to buy opposition.

Voters want Congress to say no to the tobacco industry. More than 85 percent say Congress should support the administration's effort to protect children.

Write your Members of Congress today (U.S. Senate, Washington, DC 20510; U.S. House of Representatives, Washington, DC 20515). Tell them ***America's children aren't for sale.***

To learn more, call ***1-800-284-KIDS.***

CAMPAIGN for TOBACCO-FREE Kids

This ad sponsored by the Congress of National Black Churches; American Academy of Family Physicians; National Association of Elementary School Principals; Catholic Health Association; InterHealth/Protestant Health Alliance; National Association of County and City Health Officials; National Association of Evangelicals; American Public Health Association; General Board of Church and Society of the United Methodist Church; Secondhand Smoke Awareness Program, National Medical Association; and NETWORK: A National Catholic Social Justice Lobby.

Robert C. Byrd Health Sciences Center of West Virginia University News

New WVU web site for physicians, alumni now on line

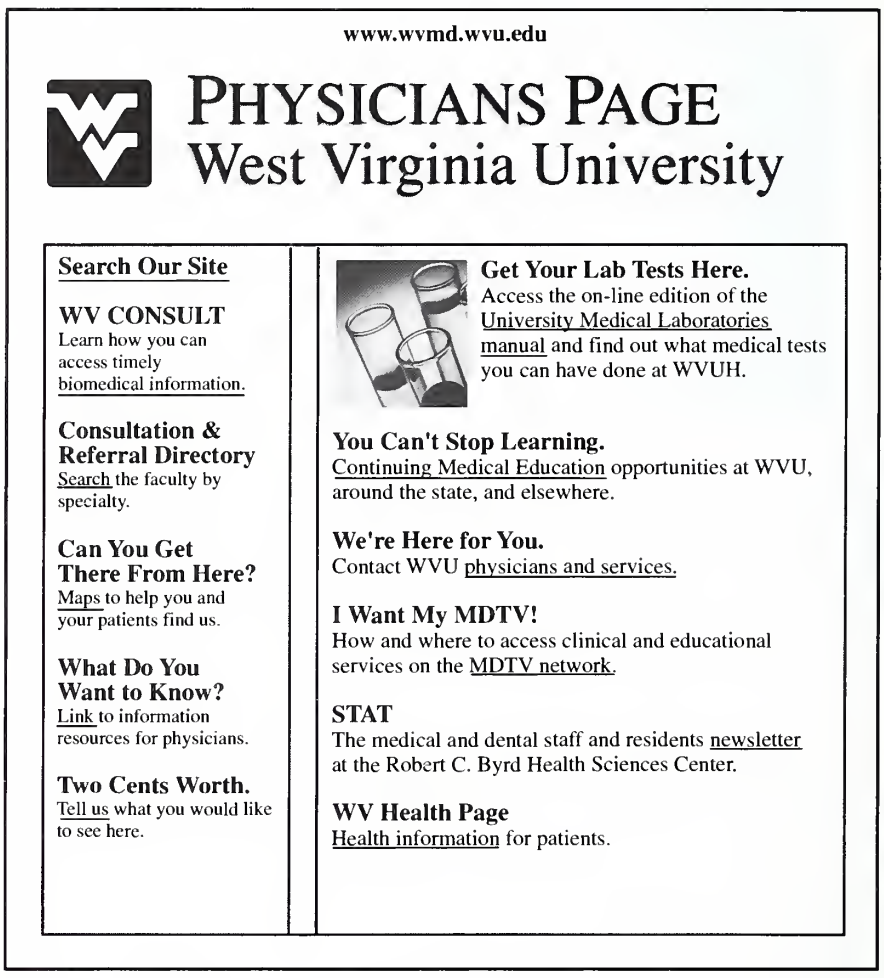
West Virginia physicians looking for a free, direct pipeline into health information on the Internet now have a new home: the West Virginia University Physicians Page.

The site, at **http://www.wvmd.wvu.edu**, provides links to services at WVU and to information worldwide. It includes comprehensive continuing education schedules - including both on-campus programs and courses available at sites around the state. Users can also request CME transcripts or personalized mini-residencies by e-mail.

One of the services expected to be heavily used is a directory of WVU School of Medicine faculty. It can be searched by specialty, special interest, or physician name. Once a physician is found, he/she can be contacted through the MARS line; e-mail links to faculty will be provided as the system develops.

The site features an online guide to University Medical Laboratory services, provides a link to WVU's CONSULT library of medical information and other materials of interest to West Virginia physicians.

Alumni and other physicians around the state can keep up with activities on the WVU campus with the online version of STAT, the medical and dental staff newsletter for the Robert C. Byrd HSC. Maps and directions to WVU are online in a form that can be printed out and provided to patients who are traveling to WVU for services.



Ducatman named chair of Community Medicine

Ducatman

Dr. Alan Ducatman, director of the Institute of Occupational and Environmental Medicine at WVU, has been named chair of the Department of Community Medicine.

Dr. Ducatman, a leading researcher and clinician in occupational medicine, has been acting chair of the department since Dr. R. John Pearson's retirement in 1996. He joined the WVU faculty in 1992, and since that time he has received three national awards for his work.

Medicare oks PET use

Positron Emission Tomography scans for detection and staging of lung cancer is now covered by Medicare. This decision was based, in part, on research into the effectiveness of PET conducted at WVU by Dr. Naresh Gupta, director of the WVU PET Center.

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Marshall University School of Medicine News

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

New department devoted to treating cardiovascular disease

The Marshall University School of Medicine has created a Department of Cardiovascular Services that will address both the medical and surgical aspects of cardiovascular disease. Thoracic surgical services will be provided as well.

Dr. John D. Harrah has been named chairman of the new department, according to **School of Medicine Dean Dr. Charles H. McKown, Jr.**

"I can think of nothing more fitting than to have Dr. Harrah, who brought open-heart surgery to Huntington when he joined the Marshall faculty in 1977, rejoin our full-time faculty to lead us in this new endeavor," Dr. McKown said.

Dr. Harrah called the melding of medical and surgical services a progressive step.

"Dr. McKown is taking a farsighted approach," Dr. Harrah said. "In the private practice world there are heart institutes that combine cardiology and cardiac surgery, but this is a new concept to the academic world. It will provide benefits academically to students, residents, and fellows, and equally as important, provide benefits in patient care."

A native of Greenbrier County, Dr. Harrah received his M.D. from the University of Virginia School of Medicine. He did his surgical internship and residency at Johns Hopkins Hospital and the University of Virginia, followed by a cardiovascular and thoracic surgery residency at the University of Virginia. He completed fellowship training at the National Institutes of Health and the USAF School of Aerospace Medicine, as well as a cardiovascular fellowship at the Texas Heart Institute with Dr. Denton Cooley. He also has a master of business administration degree from MU.

Cardiothoracic surgeon **Victor A. Ferraris, M.D., Ph.D.**, also has joined the new department. A graduate of Jefferson Medical College, he did residencies in general and cardiothoracic surgery at Fitzsimons Army Medical Center and Letterman Army Medical Center. He received his Ph.D. from the University of Colorado.

MU's cardiology faculty members are now serving in the Department of Cardiovascular Services.

Dr. Robert Touchon will serve as vice chair of the new department. A graduate of St. Louis University, he joined the MU faculty as chief of the Cardiology Section in 1982. He did his internal medicine residency at Santa Barbara Hospitals, his clinical cardiology fellowship at St. Vincent Hospital at the University of Southern California, and an NIH-sponsored cardiovascular research fellowship at UCLA Medical Center.

Dr. Mark Studeny, who received his M.D. degree from Marshall, did his internal medicine residency at Texas Tech and his cardiology and interventional cardiology fellowships at Marshall and director of the Cardiac Catherization Laboratory at St. Mary's Hospital.

Dr. Paulette Wehner received her M.D. degree from MU, where she also did her residency in internal medicine and fellowships in cardiology and interventional cardiology. She is director of the Adult Training Program in Cardiovascular Medicine.

Dr. Silvestre Cansino, a graduate of Far Eastern University in the Philippines, did his internal medicine residency at Bronx-Lebanon Hospital in New York and his cardiology fellowship at the Graduate Hospital at the University of Pennsylvania in Philadelphia.

Dr. Salmon Malik earned his medical degree from King Edward Medical College in Pakistan. He did his residency in internal medicine at the University of Utah Medical Center and his cardiology fellowship at the University of Arkansas for Medical Sciences.

Suellen Ferraris, Ph.D., will join the department as director of research. A graduate of the University of Colorado, she previously worked as a research chemist at Letterman Army Institute of Research and a research assistant professor in the Division of Cardiothoracic Surgery at Albany (N.Y.) Medical College.

Members of the department will provide services at each of MU's affiliated hospitals: Cabell Huntington Hospital, St. Mary's Hospital and the Huntington VA Medical Center.

Research Day set

Marshall students, residents, faculty and guests will gather April 6 and 7 for the Medical School's annual Research Day activities. Organizers anticipate 50 poster and oral presentations covering clinical research, case studies, and basic science projects.

This year's featured speaker is **Dr. Jerome Brod**, professor of medicine and director of the Pulmonary Center at the Boston University School of Medicine. He is nationally and internationally known for his research on lung development, especially in the area of pulmonary surfactants.

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This program is a joint effort of the West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Epidemiology and Health Promotion, Division of Surveillance and Disease Control, AIDS Program, the WVU School of Medicine Section of Infectious Diseases and Office of CME, and the WVU School of Pharmacy.

Contact the Office of Continuing Medical Education at 1-800-WVA-MARS or (304) 293-3937 or e-mail **cme@wvu.edu** for more information.

This program is being sponsored in cooperation with the West Virginia Division on Alcoholism and Drug Abuse, the West Virginia Department of Education, the West Virginia American Red Cross, and the Mid-Atlantic AIDS Education & Training Center.

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American Heart Association

West Virginia School of Osteopathic Medicine News

Several physicians with WVSOM connections receive fellowships

Tom Steele, D.O., an associate professor of FP at WVSOM; Irvine Prather, D.O., a WVSOM alumnus now practicing in Texas; and Don Newell Jr., D.O., of the WVSOM Institutional Board of Advisors, were among the physicians receiving fellowships from the American College of Osteopathic Family Physicians at the Annual American Osteopathic Association Convention in San Antonio, Texas.

Several physicians with WVSOM connections received fellowships from the American College of Osteopathic Family Physicians (ACOFP) at the recent Annual American Osteopathic Association Convention in San Antonio, Texas.

The physicians presented ACOFP fellowships included: WVSOM faculty member Tom Steele, D.O., associate professor of family practice; Don Newell Jr., D.O., a physician in Oak Hill; and a member of the WVSOM Institutional Board of Advisors; and Irvine Prather, D.O., an alumnus of WVSOM now practicing in Texas.

Student earns second scholarship

Jackson

Dainty Jackson, a third-year medical student at WVSOM, has received the 1997 Sherry R. Arnstein Minority Student Award from the American Association of Colleges Osteopathic Medicine for the second time.

Jackson, a native of Largo, Md., was chosen for this scholarship award for a paper she wrote on how osteopathic medical schools could attract more minoritity students.

National Osteopathic Medicine Week benefits community

WVSOM President Olen Jones, Ph.D. (*left*), and guest speaker Bruce Peterson, D.O., cut the cake at the kick-off celebration for National Osteopathic Medicine Week. Also pictured are student government representatives Jonathan Burress, Brett Faulknier, Dino Beckett, and Erica Barringer.

Lewisburg senior citizens, school children, and others in the community reaped the benefits of National Osteopathic Medicine Week on November 2-8 as students from the WVSOM hosted numerous activities at the school and throughout the local area.

Activities commenced with a "Cake Cutting Ceremony" for the public at the Roland P. Sharp Alumni Conference Center on the WVSOM campus. Bruce Peterson, D.O., a former member of the West Virginia House of Delegates and WVSOM alumnus was the featured speaker.

West Virginia delegates Tom Campbell and Richard Flanigan presented a plaque from the Legislature to WVSOM President Olen E. Jones, Ph.D., and members of the Student Government Association. Events continued with the "Medical Student for a Day" program in which 20 students from Greenbrier East High School in Lewisburg paired up with WVSOM students for the day.

Two students awarded scholarships

Abigail Winters, a fourth-year student at WVSOM, recently received a $5,000 Zeneca Pharmaceutticals underserved healthcare grant award, and Connie Anderson, another fourth-year student, was presented with a $5,000 scholarship from the Auxiliary to the American Osteopathic Association.

EVEN WITH MS, GEORGE GANT HAS DESIGNS ON THE FUTURE

George is working his way up the corporate ladder a little differently. He's using a "scooter." Because George has multiple sclerosis, a chronic disease of the central nervous system.

A chemist, George is not content to sit back and mount up patents and industry awards. He has earned honors from almost a dozen state and local organizations for his contributions to the community.

Now, George develops quality improvement programs for his Michigan-based employer and helps to integrate other physically challenged workers into the corporate mainstream.

While his physical future is uncertain, George is unyielding in his belief that someday a cure for MS will be found. The National Multiple Sclerosis Society is bringing that day closer by funding vital research in genetics, virology and immunology. To find out more about the Society and its services, call 1-800-624-8236. Help a quarter of a million Americans with MS help themselves.

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It's time to tax tobacco, phase out provider tax!

With the Legislative Session now in full swing, the WVSMA Alliance will continue to actively pursue a tax on tobacco and a phaseout of the provider tax by 25% every year for the next four years. At press time, Speaker of the House of Delegates Robert Kiss was still determining if there is enough support for such a bill. We, as Alliance members and the spouses of physicians, cannot ease up on our efforts to reduce the tax and stress to legislators the importance and significance of such a bill.

Why single out tobacco?

*Tobacco is the leading cause of death and disease in the U.S. Smoking kills more people than AIDS, alcohol, car accidents, fires, cocaine, heroin and suicides combined. In West Virginia, one in every four deaths is tobacco-related. Approximately 4,200 West Virginians die each year from tobacco-related illnesses.

*Tobacco use is a pediatric disease. Virtually all new smokers are children. The nicotine is highly addictive and our children get hooked in a very short time.

*Tobacco produces no health benefits. Unlike some food products which provide nutritional benefit but also contribute to the risk of heart disease, tobacco provides no benefits and is harmful under all circumstances. Unlike alcohol, tobacco kills even when used in moderate amounts.

Why tax tobacco?

*Tobacco is an economic burden on the state. West Virginians pay $546 million each year in tobacco-related health care costs. If the price of cigarettes covered all of the health care costs in West Virginia resulting from smoking, a pack would cost $2.94 rather than the current $1.60.

*Higher taxes would discourage children from starting to and continuing to smoke. Research shows that a 10% price increase in cigarettes can be expected to produce a 7%-14% reduction in tobacco consumption by youth. West Virginia is number one in the nation in youth tobacco use and number one in the nation in smokeless tobacco use. Our number one priority should be reducing tobacco consumption by children.

*Since many Medicaid patients are tobacco users, it is only fair they should be taxed on tobacco. Call it a user fee to help pay for the diseases that will occur in the future.

*Tobacco taxes have not kept pace with inflation. In 1977, tobacco excise taxes accounted for 50 percent of the retail price. The higher cigarette prices of today are the result of price increases from tobacco manufacturers.

*Two-thirds of West Virginians believe that cigarettes and smokeless tobacco products should be taxed at the same rate, according to the 1995 Smokeless States survey. Currently, cigars, smokeless tobacco, loose tobacco, rolling papers, and other tobacco products are exempt from the excise tax levied on cigarettes.

I am not sure how successful we will be in obtaining a tax on tobacco, and lowering the provider tax, but I am sure that we should be relentless in our efforts.

Carole Scaring
Legislative Chairman, WVSMAA
Policy Chairman, Coalition for a Tobacco-Free WV

Unite!

WESPAC

Join the West Virginia State Political Action Committee today and unite with your fellow physicians who need your support in the state Legislature.

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Contributions are not limited to the suggested amount. Neither the AMA, the WVMSA nor the component medical societies will favor or disfavor anyone based on the amount of or failure to make PAC contributions. Contributions are subject to Federal Election Commission Regulations and the West Virginia Secretary of State Regulations.

We can make beautiful music together

Greetings!

For those of you who didn't get to attend the recent WVSMA-MSS Annual Meeting, you really missed an excellent meeting. It was a privilege to hear Robert Beran, Ph.D., executive director of the National Residency Match Program. Dr. Beran presented us with valuable information regarding how the match works, how the NRMP has changed its format to benefit students, and how we should approach ranking our list.

Dr. Anthony DiBartolomeo from WVU and Dr. Robert Walker from MUSOM, who are both attendings, clinical professors, and residency chairs at their respective institutions, discussed the match from their schools' perspectives, how they determine their rankings, and what they look for in a highly-ranked candidate. Overall, we learned a great deal about this important event which will affect all of our lives in years to come.

Dr. Walker also gave an interesting lecture on *"Who Controls Medicine? Is Autonomy Impossible?"* He discussed topics concerning physician equity and the perils of signing it away to an HMO or large group, under the auspices of landing a big salary right out of residency. He pointed out that by doing such, we completely undermine our ability to maintain our autonomy. If autonomy is the goal, then our equity must be the foundation of our practice. In addition, Dr. Walker emphasized that if we are to survive and thrive in any marketplace we must continue to practice the best medicine possible, always keeping the patient's best interest at heart.

We closed the meeting with our annual business meeting, including the final preparations for the WIMOK meeting in March. Furthermore, we accepted nominations for state officers for the coming year which means I will no longer be serving as your president. It has been an honor and privilege serving you during the past year. In many ways, you have shown me that the future of our profession is in good hands. As I have had the pleasure of meeting our colleagues from around the state, I have been touched by the reverence and respect we all share for the art of medicine. I have grown to appreciate more and more what an incredible difference we as students can make.

As Dr. Thomas Chang, WVSMA President, poignantly stated at our annual meeting "a symphony produces beautiful music in as much as the individuals unite themselves for a single purpose, otherwise, all is chaos." To extend his metaphor one step further, I would like to add this point. One does not compose concertos overnight. Bach, Beethoven, Straus, Gershwinn — all names we recognize as the world's foremost composers, spent their lives honoring their craft, manipulating a limited coffer of notes, subjecting their works to the utmost scrutiny, writing and rewriting. The world's most timeless and cherished music became such because these artisans were willing to struggle and change until they were greeted by a moment of bliss . . . perfection.

I submit to you, we can make a difference. We can make beautiful music together. The struggle will be hard, but the art of medicine will survive only in as much as we, the artisans, strive to shape and perfect its practice. Otherwise, all is chaos.

Jason Harrah, MSIII
WVSMA-MSS President

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March 27-29, 1998
WVU School of Medicine
Morgantown, WV

Obituaries

Jose Arcinas Celis, M.D.

Jose Arcinas Celis, 66, of Dover, Del., formerly of Charleston, died at home on December 11 of cancer.

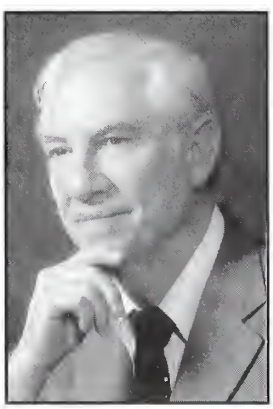
Dr. Celis received his medical degree in 1955 from the University of Santo Tomas in Manila, Philippines. He interned at the 6208th USAF Hospital at Clark Air Base in the Philippines from 1956-60, and then completed residencies at Santo Tomas University Hospital and at Hackensack Hospital. From 1962-64, Dr. Celis did a residency in urology at New York University, Bellevue Medical College, where he was a chief resident. In addition, the following year he was a research fellow and clinical instructor at New York Medical Center.

In 1967, Dr. Celis moved to Charleston, where he practiced urology for 30 years. He was on the staff at Charleston Area Medical Center and St. Francis Hospital, where he served as chief of urology.

A diplomat of the American Board of Urology, Dr. Celis was a fellow of the American College of Surgeons and of the Philippine College of Surgeons. He had been a WVSMA member since 1967, and was also a member of the AMA, the American Urological Association, the American Fertility Society and Kanawha Medical Society.

Surviving: wife, Hazel; son, Jose Celis Jr. of Messena, N.Y.; daughters, Cristy Bell of Allentown, Pa., Deborah Celis of South Royalton, Vt., brothers, Jesus of St. Louis, and Vicente of Manila.

Calvin H. Frazier, M.D.



Dr. Calvin H. Frazier, of La Canada Flintridge, Calif., died December 21.

Dr. Frazier was born in Powellton, W.Va., and attended West Virginia University and the University of Virginia before serving as a bombardier in WWII

After his military service, Dr. Frazier returned to complete his medical degree at the Medical College of Virginia. He did an internship in general surgery at Jackson Memorial Hospital in Miami, and then completed residencies in orthopedic surgery at Charity Hospital, LSU Service, in New Orleans, and at the University of Mississippi in Jackson.

Dr. Frazier became certified by the American Board of Orthopedic Surgery in 1961. He completed fellowships in hand surgery at the University of Iowa in 1970, and in hip surgery at Massachusetts General Hospital in 1972.

Dr. Frazier practiced orthopedic surgery for 40 years throughout California. He retired from private practice in February 1997.

Surviving: wife, Dawn Ishimaru Frazier; sons, Donald and Douglas; daughter, Heather; and brother, Claude Frazier, M.D. and sister, Peggy Frazier.

The family suggests memorial donations to Verdugo Hills Hospital Foundation, 1812 Verdugo Blvd., Glendale, CA 91208.

Joseph A. Smith, M.D.

Dr. Joseph A. Smith, 77, of Dunbar died January 22 in Thomas Memorial Hospital, South Charleston.

Dr. Smith was a retired physician from Dunbar Medical Associates, formerly Smith, Merrifield and Hively. He attended Glenville State College and was a graduate of West Virginia University and the Medical College of Virginia, where he earned his medical degree in 1950. He interned at Charleston General Hospital from 1950-51 and then began practicing in Dunbar.

Dr. Smith served as president of the WVSMA from 1977-78 and and as president of Kanawha Medical Society in 1967. He was also a member and former president of the American Academy of Family Physicians, and was a member of the AMA, the Southern Medical Association, and the West Virginia Medical Licensing Board. Dr. Smith served on the advisory board of the United National Bank, and was a member of Humphreys Memorial United Methodist Church and the Dunbar Rotary Club.

Dr. Smith was an Army Air Corps captain during WWII.

Surviving: wife, Helen Fisher Smith; sons, Joseph A. Jr, of Rocky Mount, N.C., and James F. of Greensboro, N.C.; daughter, Mary Elisabeth Smith of Charleston; brother, William H. of Huntington; sisters, Jennette S. Clark of Homestead, Fla., and Anne Smith of Charleston; and five grandchildren.

The family suggests donations to Humphreys Memorial United Methodist Church, 1400 Grosscup Ave., Dunbar, WV 25064.

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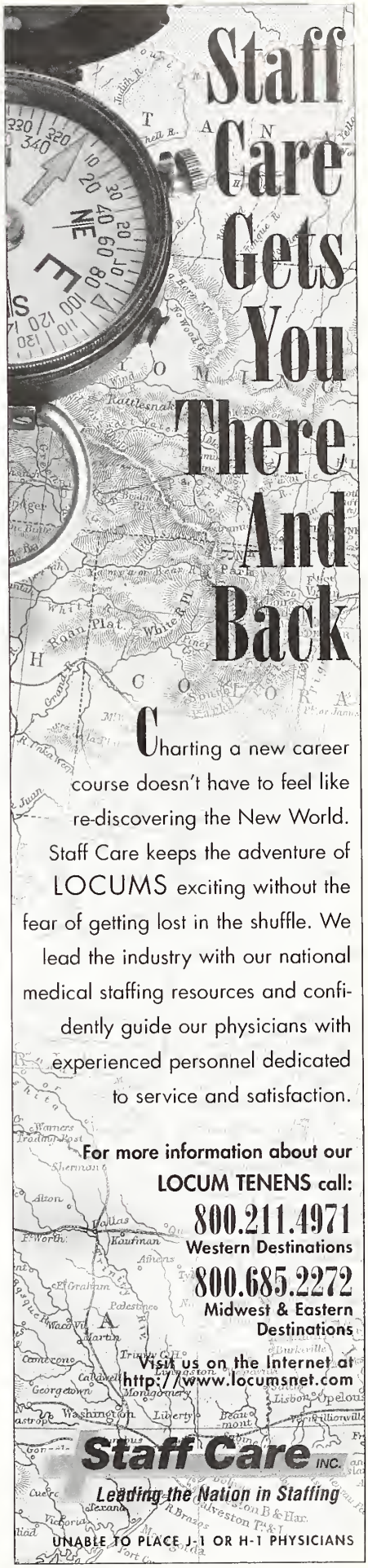

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All scientific and special articles being submitted to the *West Virginia Medical Journal* must be created on an IBM compatible disc in Wordperfect 6.1 or earlier versions, or in ASCII. If the manuscript contains tables, the main body of the manuscript and references should be saved as one item, i.e., *article*, and then each table should also be saved as a separate item, i.e., *Table 1, Table 2.*

All scientific manuscripts should be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."* Papers will not be considered for publication if they have already been published or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced, have page numbers on every page and include the following:

1. Title page.
2. An abstract of no more than 150 words.
3. Text.
4. Acknowledgements.
5. References in parentheses numbered consecutively. No more than 10 references will be published and then a statement will appear stating that the author should be contacted for the other references.
6. Tables.
7. Legends for illustrations.

All persons designated as authors should qualify for authorship. Each author should have participated enough in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by its most commonly known trade name in parentheses.

Tables, figures and photos should be numbered, and indicated with parentheses whenever they are mentioned in the text, i.e. (Table 1), (Figure 1). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author at a cost of $13 for each photo. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be created in black and white.

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364. Other types of articles are usually only reviewed by the editor and managing editor and should be mailed to the same address.

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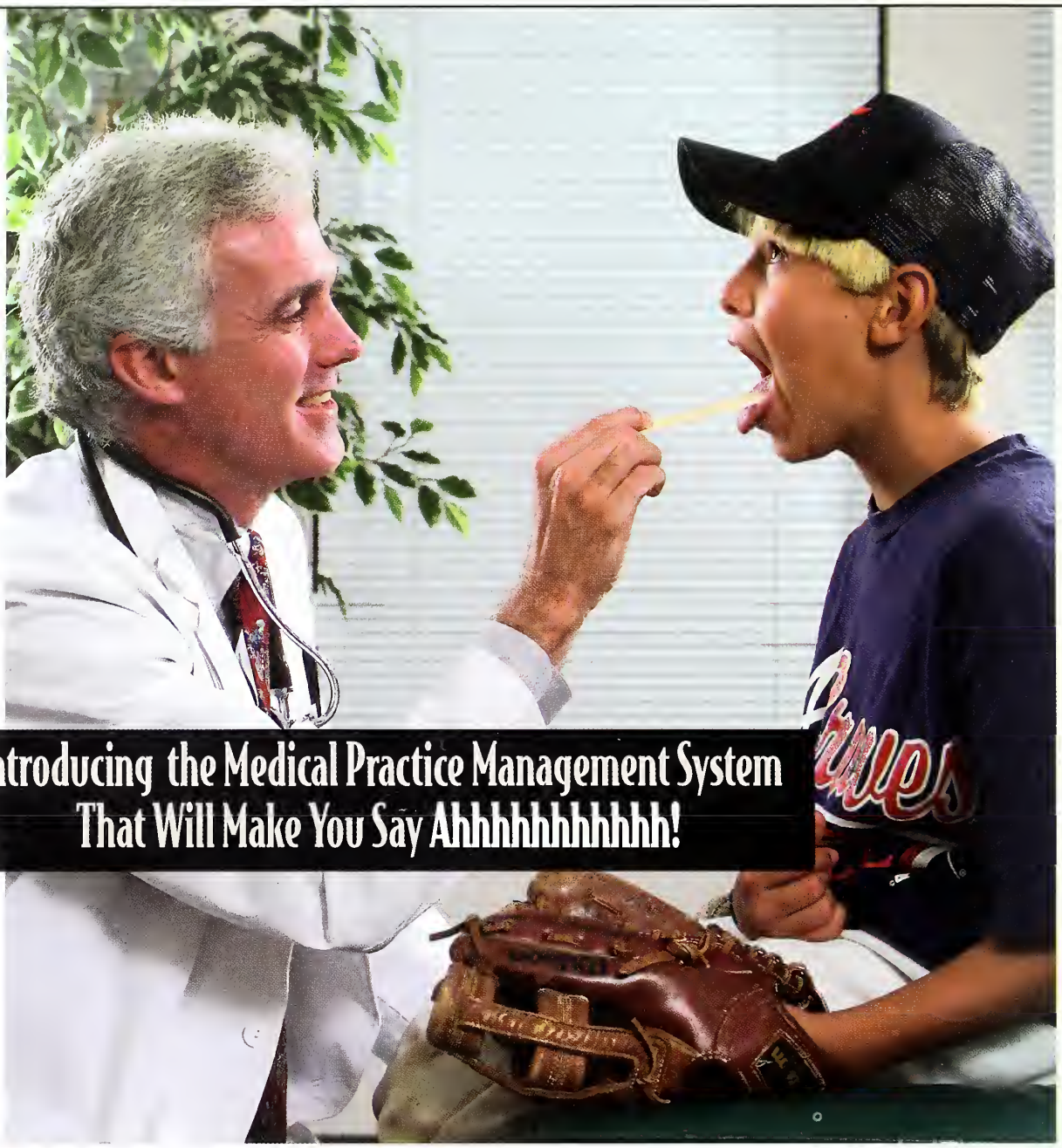

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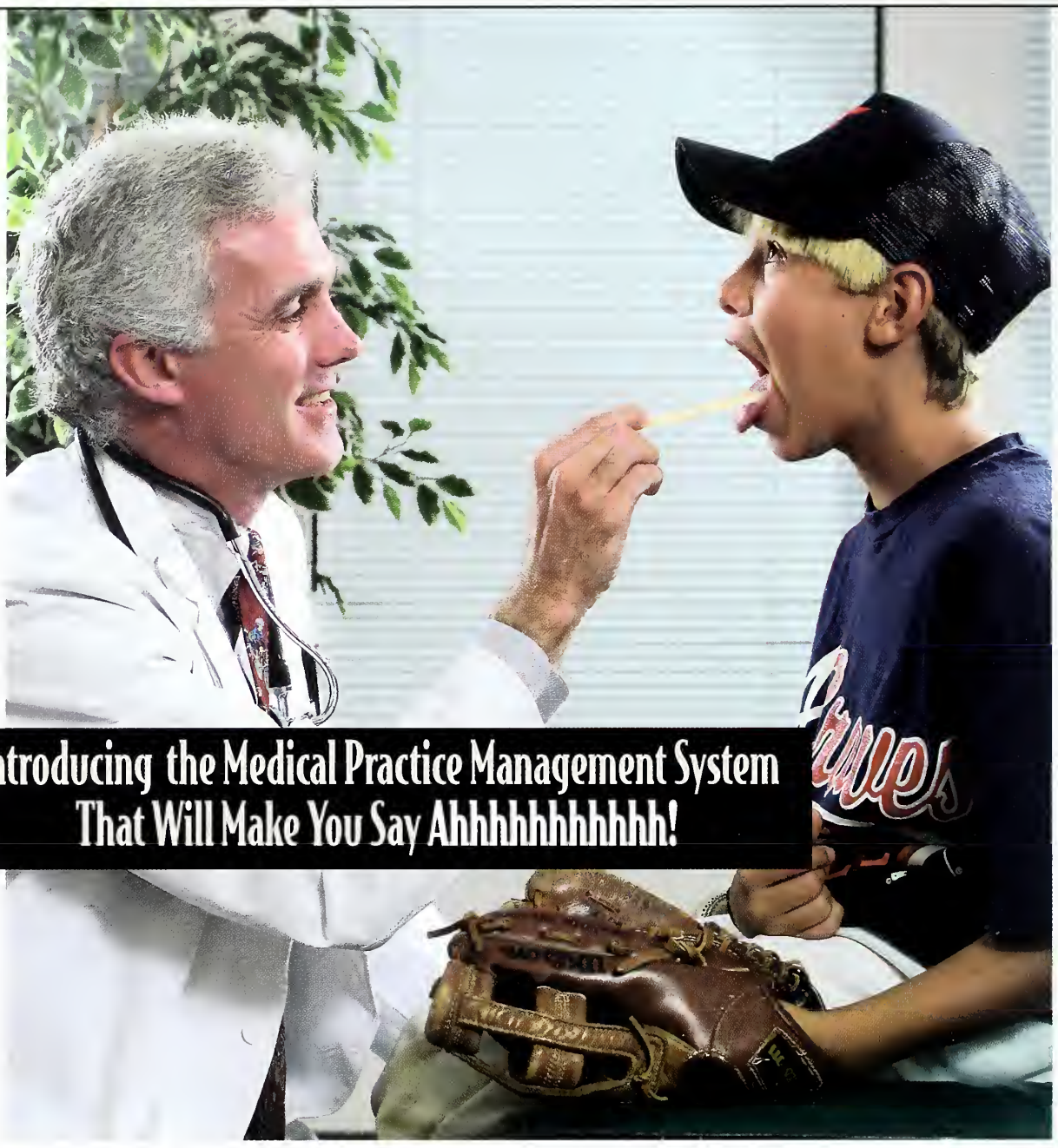

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On The Cover

A peacock enjoys a sunny day at the Chandlers' farm in Elk Hills near Charleston.

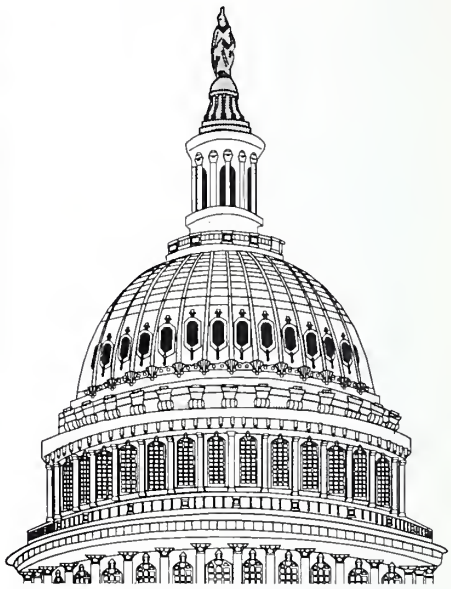
Photo by Nancy L. Hill, Managing Editor
West Virginia Medical Journal

An overview of the 1998 Legislative Session

The lobbying efforts of the WVSMA this year have paid off with several successes in the 1998 legislative session, such as the rejection of the Provider Service Organization (PSO) bill and the passage of the bill regarding the Child Health Insurance Program.

However, as a whole, the 1998 session won't be known as a landmark year for the enactment of comprehensive health care legislation. This fact should motivate us to bolster our role as lobbyists in the future; our profession and the well-being of our patients depend on it.

The following is an overview of our accomplishments this session:



- Lawmakers refused to take action on the bill drafted by the West Virginia Hospital Association regarding the development of PSOs. Our association lobbied hard against this for several reasons:

  1. The federal government has yet to promulgate regulations addressing Medicare PSOs, which are newly allowed via the Balanced Budget Act;
  2. The financial requirements in the bill were too low; and
  3. Rather than attempting gradual implementation, the bill called for an immediate, major overhaul of the health care delivery system.

- Passage of the Child Health Insurance Bill allots more funding for health care services to families just above the poverty level. By passing this bill, the state will receive $23 million annually from the federal government and will provide $5 million of its own funds to the program. The governor plans to select a seven-member board to handle this project, and I propose that it include at least one physician, preferably a retired pediatrician to avoid a conflict of interest.

- The WVSMA also spent a great deal of time lobbying against several bills which would have permitted advance nurse practitioners to serve as gatekeepers in lieu of primary care physicians in HMOs. These bills clearly would have created a second-class system of health care.

- Another major achievement of this session was the enactment of a bill addressing pain management for terminally-ill patients. The Intractable Pain Bill (H.R. 4058) provides new standards for physicians prescribing narcotics for persons suffering intractable pain.

- The passage of a bill regarding potential HIV exposure broadens the powers of physicians because it allows for a physician to test the HIV status of a patient in situations where workers would be at high risk for exposure.

- Legislators approved the HMO rules proposed by the West Virginia Insurance Commissioner which contain key aspects of the Patient Protection Act. We supported the proposed rules wholeheartedly because they will prohibit some of the most abhorrent managed-care practices, such as physician gag clauses.

- Passage of the Birth Score Test Bill requires parents of newborns who are delivered at home by mid-wives or in non-licensed facilities to take a birth-score test by a primary care physician within 10 days of the birth or face civil penalties. This bill, supported by the WVSMA, responds to the state's disturbing record for the highest post-natal mortality rates, due to poor attendance of regular physicians' visits following birth.

- The WVSMA considers passage of the Optometry Bill to be a success because physicians' input helped reshape the bill before it was presented for a vote. The bill originally called for unrestricted prescriptive authority of optometrists for oral anxiolytics, corticosteroids and narcotic analgesics. The WVSMA and other medical associations opposed the bill in the interest of patients' protection. A legislative rules-making committee called for a meeting among five physicians (including myself) and five optometrists to come to an understanding on the issue, and the bill was revised, eliminating oral anxiolytics, and limiting oral narcotic analgesics to three-day prescriptions and oral corticosteroids to six-day prescriptions.

While the introduction of a comprehensive tort reform bill by Governor Underwood was historic, little progress was made on the issue this year. One small bill did pass which purports to alleviate liability issues for physicians who provide volunteer services at athletic events. However, Senate Bill 744 reads that physicians who gratuitously and in good faith render emergency care "shall not be held liable for any civil damages as a result of such care and treatment, or as a result of any act or failure to act in providing or arranging medical treatment *to an extent greater than the applicable limits of his or her professional liability insurance policy or policies* when such care is rendered in accordance with the acceptable standard of care . . . "

In other words, this bill which was touted as legislation that would alleviate physicians' fear of being sued for providing care at sporting events, doesn't do that at all. A physician can still be sued - - but just to the limit of his/her malpractice coverage. Attempts to later amend this bill to provide broader tort reform measures were ultimately rejected.

Despite the massive effort made by a broad coalition of groups, the tobacco tax was ultimately defeated, with legislators standing by their "no new taxes" commitment. However, one important tobacco-control bill was passed which broadens sting operations and increases penalties to retailers selling tobacco products to minors.

Absent a mechanism to fill the hole in the Medicaid budget, the repeal of the provider tax died late in the session, as most provider groups sought a phase-out approach that was equitable to all. **We have been given assurances by the legislative leadership that the repeal of the provider tax will be addressed next year as part of a massive tax system overhaul.**

We regret to report that despite its passage in the House of Delegates, the Medical Practice Act reform bill died in the Senate. We propose that the WVSMA's Legislative Committee discuss intensifying its efforts for possible enactment next year.

In summary, we should applaud our successes this session, but strive to improve our relations with our legislators. Issues affecting physicians and their patients may have fared better had we been more directly involved in the process. We must remember that most of our legislative priorities are met with opposition - - such as plaintiff attorneys battling tort reform - - and we must match their lobbying efforts head-on.

It is imperative that every physician cultivate a strong, ongoing relationship with his or her legislators and educate them on issues that are important to us. By doing so, legislators will turn to us for input when such issues come before them during the legislative session.

Thomas H. Chang, M.D.

A golf cart ruling

I have been following with interest the dispute between young Casey Martin and the PGA.

A recent court ruling has decreed that Martin be allowed to ride a cart when he plays in Nike Tour events. In his first tournament since the ruling, the weather was unseasonably cold. The PGA refused to allow him a cart with a wind-screen, meaning that he was forced to deal with a much greater wind-chill factor than his colleagues who were able to walk. The other ruling body for men's golf in this country, the USGA, has yet to establish a policy should Martin qualify for the U.S. Open. Both bodies have a dichotomy of opinion and a conflict of interest on the issue of carts and their appropriate use.

My institutional memory of the game goes back almost 50 years when I started tagging along with my Dad on Saturdays. I was too little to play by that era's standards; I was just along for the WALK ... Yes, everybody walked! Riding wasn't an issue because there were no carts. Caddie programs were still thriving and they provided great opportunities for teenagers to pick up some income, but more importantly to be exposed to some great role models. I know of at least three of my Dad's former caddies who are practicing physicians. One of them is a medical school dean.

I remember quite well when the course where we played got its first cart. It must have been about 1956. The rules for its use were quite simple — anyone could ride if they had a doctor's excuse saying they couldn't walk! It was a marvelous device. One of my Dad's cronies who could only walk a few holes was able to play a full 18-holes again and enjoyed the game for many years thereafter.

A few years ago I played in a scramble with a man who had a severe disability involving both lower extremities. It was difficult for him to walk and he couldn't hit the ball far but he could putt the eyes out of a snake. Largely on the basis of his putting, we won that day. Without a cart he wouldn't have been out there.

For the rest of us, while riding may be a convenience, it is detrimental both to our health, and to our game. On the same course, (albeit not that great anyway), my game is usually about three strokes better when I walk. Contrary to the conventional wisdom it is really faster to walk than it is to ride.

Clubhouse managers and club pros quickly realized the revenue potential of carts and the relative ease of management of a fleet of motorized machines as opposed to a caddieshack full of teenagers. It didn't take long for carts to become the norm rather than the exception.

This brings me to the dichotomy of opinion and conflict regarding the use of carts by the USGA and the PGA. Both PGA tour events and USGA sanctioned events require participants to walk. On the other hand, many USGA member clubs and PGA club professionals either require the use of a riding cart or actively discourage walking. The revenue stream from cart rentals has apparently become a major budgetary factor.

I doubt if Casey Martin's case will be the last on this issue. To prevent further embarrassment and the costs of litigation, the games ruling body should act quickly and issue the following simple ruling:

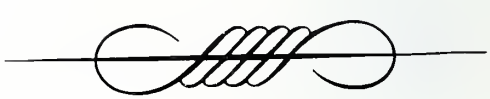
Any participant in the game of golf at any level (amateur or professional) with a documented physical infirmity which prevents walking may ride a cart. All others must walk!!!

F. T. Sporck, M.D.
Associate Editor

Welcome!

We would like to officially welcome Dr. Tom Sporck to the Publication Committee with this issue and demonstrate above his initial editorial concerns. We suspect he will have others.

We do not abandon our assault on plaintiff attorneys, HMOs, corrupt politicians and other thieves; we simply take this opportunity for a change of pace to gather our thoughts.



Stephen D. Ward, M.D.
Editor

Legislative Reception

(Top left) **WVSMA Alliance President Kathy Fortunato and her husband, Dr. Michael Fortunato, were glad to see one of their Ohio County legislators Delegate Gil White at this year's Legislative Reception.** *(Center)* **Dr. Constantino Amores and his son, Delegate Jon Amores talk with Senator John Pat Fanning.** *(Top right)* **WVSMA President Dr. Thomas Chang visits with guests.** *(Bottom left)* **Guests line up at the busy registration table to pickup their nametags.** *(Bottom right)* **WVSMA Director of Operations Tim Allman discusses issues with Senator Donna Boley.**

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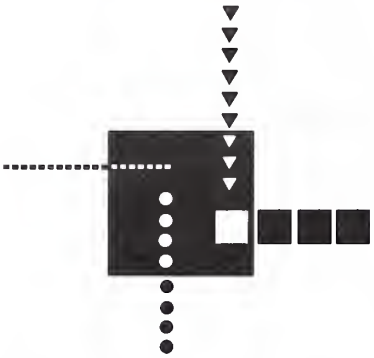

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Your success depends on your involvement! Plan today to attend the 1998 Annual AMA-OMSS Assembly Meeting on June 11-15, at the Sheraton Chicago Hotel and Towers. To receive more information and registration materials, please call **800 621-8335 and ask for the Department of Organized Medical Staff Services.**

* The American Medical Association Organized Medical Staff Section (AMA-OMSS) leads and assists grassroots physicians, individually and in groups, to organize and reclaim their role as medical leaders and advocates for excellence in patient care, professionalism, and the integrity of the patient-physician relationship. We provide practical educational forums, focused policy development, and grassroots support through the Federation.

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SPECIAL SECTION

Highlights of the WVSMA's

1998 Mid-Winter Clinical Conference

The WVSMA would like to thank everyone who helped contribute to the success of the conference!

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(Top left) **Dr. Robert D'Alessandri, dean of the WVU School of Medicine, emphasizes a point about patient ethics while moderating the "*Controversies in Medicine Session*" at this year's Mid-Winter Clinical Conference.** *(Top right)* **Enjoying the reception sponsored by the Philippine Medical Association of WV are Eva Racadag and her sons, Ivan, Alan and Ira; Evangeline Gaugucas and her son, Alex; and Trudy Tordilla.** *(Center right)* **WVSMA President Dr. Thomas Chang is interviewed by Bev Davis, a reporter for *The Register-Herald* of Beckley.** *(Bottom)* **Speaker of the House of Delegates Robert Kiss addresses physicians and Alliance members at the Legislative Workshop which was conducted at the meeting.** *(Center left)* **Dr. Charles McKown Jr., dean of the MU School of Medicine, visits with George Rider, WVSMA executive director, and Dr. Mabel Stevenson of Huntington, at the reception co-hosted by the WVU and MU Schools of Medicine.**

(Top left) **Following his lecture on *"Calcium Malnutrition in the Elderly,"* Dr. Robert Heaney answered questions from Connie Prendergast, PAC, and Dr. Paul Francke Jr. *(Top right)* Dr. George Zaldivar discussed *"Commonly Encountered Sleep Disorders"* during his lecture for the First Scientific Session. *(Center right)* Dr. Alvin Moss and Dr. Jacqueline Glover of the Center for Health Ethics and Law at WVU in Morgantown respond to participants' questions after their presentations for *"Controversies in Medicine." (Bottom)* David Kimberling of Putnam General Hospital comments on a question during the panel discussion on *"For Profit, Not for Profit and Public Hospitals"* with Bruce McClymonds of WVU University Hospitals and Robert Savage of Camcare. *(Center left)* Scott Atkins of Acordia talks with visitors at his company's booth in the exhibit hall.**

(Top left) **WVSMA Executive Director George Rider jokes with Drs. James Comerci and Michael Fortunato in the Exhibit Hall.** *(Top right)* **Dr. Stafford Warren laughs with Dr. David Gray after his lecture for the Second Scientific Session. Dr. Robert Touchon of Marshall University, who also presented a lecture for this session, is pictured in the background talking with Dr. Paul Francke Jr.** *(Center)* **Participants visit the Exhibit Hall during one of the breaks.** *(Bottom)* **Dr. John Holt and his wife, Jean, were among the guests at the reception co-hosted by the WVU and MU Schools of Medicine.**

(Top left) Dr. Shawn Chillag presented one of the case studies for the *"Stump the Audience"* segment during the Fourth Scientific Session. *(Top right)* Doctor, lawyer and talented Southern orator Dr. Erle Peacock entertained and delighted participants with his lecture entitled *"Flawed Peer Review: A Perfect Screen for Abject Tyranny."* *(Center)* Facilitator Dr. Warren Points happily presents Dr. John Stewart with the prizes which he won at the drawing after *"Stump the Audience."* Dr. Robert Marshall (*right*) was the other facilitator for this program. *(Bottom)* Sporting his Stetson, Dr. Robert Marshall, and his wife, Dr. Mabel Stevenson, prepare to head west for their home in Huntington at the end of the meeting.

Dr. Daniel Foster: The WVSMA's Mid-Winter Hero

Many WVSMA members contribute their time and talents to the Mid-Winter Clinical Conference each year, but one person stands alone when it comes to giving selflessly - - Dr. Daniel Foster.

Since 1991 when Dr. Foster was named chairman of the WVSMA's Mid-Winter Clinical Conference Committee, he has worked tirelessly to plan and organize the meeting each year.

"Dr. Foster deserves special recognition for going above and beyond the call of duty when it comes to chairing the Mid-Winter Clinical Conference Committee," said Nancie Albright, associate executive director of the WVSMA. "No matter what I or any of the other staff members ask Dr. Foster to do, he always comes through.

"Not only does he help plan the program and obtain great speakers, he has served as a moderator many times for scientific sessions and Lunch and Learns, as well as helped with door prize drawings and other activities. Many times I have seen Dr. Foster put in a full day at the conference, leave for several hours to check on patients, spend time with his family, coach his son's basketball game and then come back to participate in the entertainment scheduled for that night," Nancie said.

Throughout her years of working with Dr. Foster, Nancie has been very impressed by Dr. Foster's easy going personality.

"Dr. Foster never makes you feel like you are an intrusion when you call him or ask him for advice on something," commented Nancie. "In fact, he is so unassuming and good natured that when he needs to call me about something, he'll say 'I'm sorry to bother you.' He is truly a pleasure to work with."

The other members of the WVSMA staff echo Nancie's sentiments and also appreciate Dr. Foster for being there for them when they need his help on a personal basis.

"I have been so impressed by Dr. Foster's genuine care and concern for others, and his down-to-earth manner," said Nancy Hill, managing editor of the *West Virginia Medical Journal*. "When my mother-in-law, Jewel, became ill and had to come to Charleston from Richwood for tests, he was really there for me and my family. He took excellent care of her and when she later developed heart problems, he promptly got her in to see a cardiologist."

Misty Ramsey, the WVSMA's receptionist, also has had Dr. Foster care for a member of her family.

"Dr. Foster performed surgery on my mother over a year ago and his caring nature has really meant a lot to me and my family," Misty said. "He explains procedures thoroughly and never makes you feel like you are taking up too much of his time. When mom was hospitalized, he checked on her several times a day, and after she was discharged, he promptly returned her calls."

WVSMA Membership Coordinator Donna Webb phoned Dr. Foster for advice when her mother was going for a breast biopsy in Ohio.

"Even though my mom was not his patient, Dr. Foster took the time to talk with me and reassure me about my questions and concerns," Donna said. "I was very touched by how compassionate and caring he was," she added.

In addition to his devotion to his family, patients and the WVSMA, Dr. Foster generously gives his time to many organizations. He is a board member of the American Red Cross, United Way, the American Cancer Society, and the West Virginia Education Fund. In 1996, he was presented the MS Circle of Leadership Award from the West Virginia Chapter of the National Multiple Sclerosis Society, for his contributions to medicine and the community.

THANKS DR. FOSTER FOR BEING YOU!!!

At the conclusion of the WVSMA's 1998 Mid-Winter Clinical Conference, Dr. Foster proudly poses with Dr. Erle E. Peacock Jr., M.D., J.D., who was a professor of his when he attend medical school at Tulane University. Dr. Foster was very pleased that Dr. Peacock, who was such a mentor to him in his career, was a speaker for this year's meeting.

Thanks Dr. Bofill, Acordia of WV and Medical Assurance of WV for a fun-filled evening!!

Dr. Rano Bofill kicks off the Beach Bash by singing his favorite tune!

WVSMAA President Kathy Fortunato, and her children, Christina and Nicholas, and Christina Dixon, WVSMA public relations director, were among the guests dancing the "Electric Slide."

Wha Ja Chang surprised and delighted the guests by playing her cello.

How low can you go? Tom Pralley of Medical Assurance of WV and Carolyn Atkinson were the winners of the limbo contest.

The following physicians won door prizes at the WVSMA's 1998 Mid-Winter Clinical Conference:

Arnold Gruspe, M.D.
WVU School of Medicine running suit, compliments of the WVU Health Sciences Center Alumni Office

Rosendro Dy, M.D.
Golf putter, compliments of National Financial Services

Victor P. Salutillo, M.D.
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Gift basket, compliments of MDTV Robert C. Byrd Health Sciences Center, WVU Morgantown & Charleston

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Gift basket, compliments of Apria Healthcare

Arnold Gruspe, M.D.
Gift basket, compliments of PrimeOne

Bill Atkinson, M.D.
Gift basket, compliments of Medical Assurance of WV and Acordia of WV

Tom Linger, M.D.
Gift basket, compliments of Acordia of West Virginia

Tim Allman and Christina Dixon of the WVSMA present Cecile Calloway with a gift certificate for the Charleston Town Center.

The following exhibitors each won a $50 gift certificate to the Charleston Town Center:

Martha Endres
WV Bureau for Public Health

Mike Eastham
SmithKline Beecham

Jason Vannatta
CORE

Beth Hammers
MU School of Medicine

Cecile Calloway
WVU Robert C. Byrd Health Sciences Center

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Female physicians become mentors for Girl Scouts

CHRISTINA R. DIXON
Director of Public Relations/ Advertising Manager, West Virginia State Medical Association, Charleston

Gesiena Jaskett looks at an ultrasound with Dr. Gina Busch, a Charleston ob/gyn.

Getting up early, making rounds and discussing medical issues was all in a day's work for four West Virginia Girl Scouts from Kanawha, Putnam and Cabell counties who played doctor for a day Monday, February 16 to earn a Medicine Career Explorer Patch.

In an effort to introduce young women to career opportunities in the field of medicine, the West Virginia State Medical Association and Black Diamond Girl Scout Council sponsored The Physicians of Tomorrow Mentoring Program. This program pairs Girl Scouts with women physicians who become their mentors for a day and help them understand the requirements and benefits of the initials M.D.

After a breakfast at the WVSMA, the girls spent the day grilling their physician mentors with questions about how they got started in medicine, what their lives are like, and what it is like to balance such a demanding career with family and social obligations.

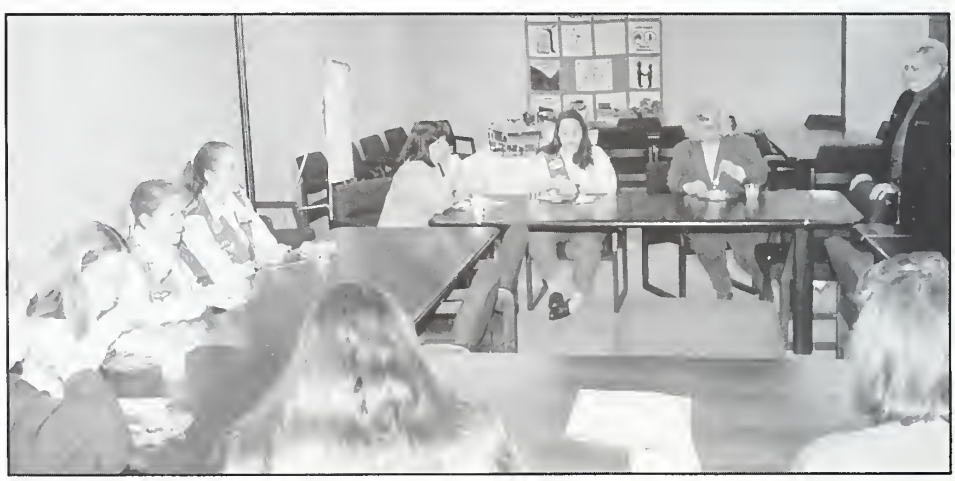
Whitney Koontz, a 15-year-old Senior Girl Scout from Hurricane, spent time with Deborah A. Bartholomew, M.D., a Charleston obstetrician/gynecologist. While she was with Dr. Bartholomew, Koontz had the thrilling experience of watching her deliver a baby by Caesarean section.

"I can't explain what an amazing feeling I had watching a child being born," Koontz said. "There are no other words to describe it except 'awesome.'"

Gesiena Jaskot, 14, a member of Girl Scout Troop 2079 in Barboursville, shadowed Gina R. Busch, M.D., a Charleston obstetrician/gynecologist.

For several hours, Jaskot was allowed to sit in while Busch met with patients and performed other duties at her practice. Dr. Busch taught her about the equipment and technology she uses on a daily basis as well as advances that will someday make her job easier.

"As a woman physician, I know the importance of career mentors and female role models," Dr. Busch said. "Not only will this project help the girls develop career interests and self-esteem,



Nancie Albright, associate executive director of the WVSMA, welcomes the Girl Scouts, their leaders, and the physicians to the breakfast at the WVSMA office.

Dr. Sarah M. Nease, a Charleston cardiologist, checks on a patient at CAMC, Memorial Division, as Girl Scout Jennifer Skurka looks on.

Dr. Deborah Bartholomew, a Charleston obstetrician/ gynecologist, shows Girl Scout Whitney Koontz some of the equipment she utilizes in her practice.

but it will also give us a chance to share the joys of medicine with the young women who follow us."

The AMA's Advisory Panel on Women's Issues and the Girl Scouts of the U.S.A. developed the Physicians of Tomorrow Mentoring Program in 1993. The program's goal has been not only to educate Girl Scouts about careers in medicine, but also to instill in them the belief that they can be anything they want in life – even a physician.

As the public relations director for the WVSMA, I noticed the Boy Scouts had already developed a program involving mentoring, but there were no opportunities in the state we were aware of that would give Girl Scouts a firsthand look at medicine.

At the breakfast held at the WVSMA office, Nancie G. Albright, associate executive director of the WVSMA, addressed the Girl Scouts about the importance of female mentors in their lives.

"We helped plan and implement this program because the Interest in the Medicine Patch is not only the first medical badge available to Girl Scouts, but the first badge to emphasize any formal career at all," Albright said.

Albright also extended a special invitation to the Girl Scouts to attend an address by Dr. Nancy W. Dickey, who will be the first female president of the AMA. Dr. Dickey will be speaking on Wednesday, August 26 during the WVSMA's Annual Meeting at The Greenbrier.

Jamie Wilcox, a Huntington 8th grader in Girl Scout Troop 2079, followed Dr. Susie Matulis, an infectious disease physician in Charleston, as she was on call at CAMC Memorial Division.

"After today, I know being a physician is a lot harder than I thought it would be," Wilcox said. "It's more work and I'm glad I found that out, but I would still consider medicine as a career."

In addition to spending time with their mentors, the girls also explored their interests in medicine through an independent study project. This project included tasks such as examining their family health history, researching the roles of physicians in various specialities, and assessing the needs of the elderly after spending time at a nursing home.

According to a survey conducted by the AMA in 1995, there were 149,404 female physicians, compared to 570,921 males. However, the trend seems to be changing.

For the first time in the 92-year history of the University of North Dakota School of Medicine, there were more women than men who entered the freshman class. The class of 2001, which started in August 1997, had 58 new students, 30 of whom were women.

For more information about the Physicians of Tomorrow Mentoring Program, contact Christina R. Dixon at (304) 925-0342 or (800) 257-4747.

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Contributions are not limited to the suggested amount. Neither the AMA, the WVMSA nor the component medical societies will favor or disfavor anyone based on the amount of or failure to make PAC contributions. Contributions are subject to Federal Election Commission Regulations and the West Virginia Secretary of State Regulations.

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Listeria monocytogenes rhomboencephalitis with cranial-nerve palsies: A case report

DOUGLAS N. SHAFFER, M.D.
Clinical Associate, National Heart, Lung and Blood Institute, The National Institutes of Health, Bethesda, Md.; Former Resident, Department of Medicine, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown

DOUGLAS A. DREVETS, M.D.
Assistant Professor, Departments of Medicine and Microbiology, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown

R. WESLEY FARR, M.D.
Associate Professor, Department of Medicine, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown

Abstract

Listeria monocytogenes rhomboencephalitis is an uncommon complication of L. monocytogenes meningitis. It presents in a typical biphasic pattern characterized by a non-specific prodromal period followed by any combination of asymmetrical, cranial-nerve palsies; cerebellar signs; hemiparesis or hypesthesia; and diminished consciousness. The survival rate is greater than 70% when appropriate antibiotic therapy is initiated early. However, approximately 60 percent of the survivors develop neurological sequelae. We present the case of a 33-year-old woman who developed L. monocytogenes meningitis with subsequent rhomboencephalitis and cranial-nerve palsie, and review the literature on this syndrome.

Introduction

Listerial brainstem encephalitis was first described in Germany by H. Eck in 1957 as an unusual form of encephalitis caused by *L. monocytogenes* which occurred only in previously healthy adults (1). Listerial rhomboencephalitis was later identified by Duffy as a distinct syndrome and first reported in the English literature in 1964 (2).

While commonly associated with bacteremia or meningitis, *L. monocytogenes* is a bacterial pathogen capable of causing rhomboencephalitis, or brainstem encephalitis. Since astute clinical suspicion and timely, antibiotic intervention favor optimal outcome for this syndrome, knowledge of its symptoms and treatment is critical.

The case we describe demonstrates an example of *L. monocytogenes* meningitis and rhomboencephalitis with cranial-nerve palsies in an adult female who is apparently immunocompetent. The absence of radiographic findings on magnetic resonance imaging (MRI) suggestive of brain parenchymal involvement in this patient is unusual since the majority of patients with listerial rhomboencephalitis have focal findings on brainstem MRI.

Case presentation

A 33-year-old woman presented with a one-day history of fever, headache and nausea. Amoxillicin was prescribed on the same day, but the headache progressed and lethargy developed on the second day of illness.

This patient was subsequently admitted to Ruby Memorial Hospital in Morgantown where she was found to be febrile (39.5^{0}C), and had nuchal rigidity and papilledema. Both Kernig and Brudzinski signs were positive. Computed tomographic (CT) scan of the head was negative.

A lumbar puncture revealed cloudy cerebrospinal fluid (CSF) with a gram-stain demonstrating rare, gram-positive rods. The CSF white blood cell count was 2,200 per mL with 88% polymorphonuclear cells, and the glucose and protein contents were 35 mg/dL and 381 mg/dL, respectively. Both the CSF and blood cultures grew *L. monocytogenes*. Other lab findings included negative HIV-1 antibodies and serum pregnancy tests, as well as a normal fasting blood glucose.

Her past medical history was remarkable only for psoriasis for which she occasionally applied a topical, medium/high potency steroid cream, clobetasol (Temovate). She had no history of diabetes, tobacco use, or alcohol consumption.

Her temperature had quickly subsided during ampicillin therapy, and her nuchal rigidity and headache resolved. However, on her second day in the hospital she developed bilateral cranial-nerve VI and peripheral, right cranial-nerve VII palsies as evidenced by acute onset of diplopia and facial weakness (Figures 1,2,3 and 4).

An MRI of the brainstem with and without contrast was unremarkable and without signs of brainstem abscess or focal lesion. By the time she was discharged, the cranial-nerve palsies had improved only slightly, but by the time she was seen for followup two and a half months later, they had resolved.

Figure 1. Patient's inability of complete abduction upon horizontal gaze to the left, demonstrates left cranial-nerve VI palsies.

Figure 2. Patient's inability of complete abduction upon horizontal gaze to the right, demonstrtes right cranial-nerve VI palsies.

Figure 3. Patient's inability to "smile" on the right side of her mouth suggests cranial-nerve VII dysfunction.

Figure 4. Patient's inability to "wrinkle" her right forehead and "smile" (Figure 3), localizes the palsy to the right, peripheral cranial-nerve VI.

Discussion

Epidemic outbreaks of listerial infections have been associated with the transmission of *L. monocytogenes* from contaminated foods such as meat and dairy products (3,4). While transient fluctuations occur annually, the incidence of all listerial infections has not significantly changed over the past two decades (5).

A decline in the incidence of listerial infections in the U.S. during 1993 has been attributed to enhanced prevention efforts by the U.S. food industry (3). However, in 1995 an increasing incidence of listerial infections was noted, particularly in previously healthy individuals as well as in immunocompromised populations such as the acquired immune deficiency syndrome (AIDS) population (6).

L. monocytogenes bacteremia and meningitis frequently occur in immunocompromised patients who are pregnant, are extremely young or elderly, are receiving immunosuppressive therapy, or have other underlying medical illnesses (5,6,7). In contrast, *L. monocytogenes* rhomboencephalitis typically presents in non-immunosuppressed, middle-aged adults without marked gender preference (4,8,9).

The frequency of brainstem encephalitis in patients with *L. monocytogenes* meningitis is uncertain. Frequencies have been reported as low as < 1% and as high as 24% (7,8). While *L. monocytogenes* meningitis occurs in neonates, no cases of *L. monocytogenes* rhomboencephalitis have been reported in this population (8,9).

The biphasic presentation of *L. monocytogenes* rhomboencephalitis usually consists of a non-specific prodromal period lasting from 5-15 days with common symptoms of headache, nausea, and vomiting. The subsequent neurological syndrome of rhomboencephalitis typically consists of cranial-nerve deficits, cerebellar signs, and hemiparesis and/or hypesthesia.

Cranial-nerve palsies occurring most commonly and in decreasing frequency are: VII, VI, IX, X, and V (8). Cranial nerves I, II, XI, and XII are often spared (4). Cranial-nerve deficits include adjacent, ipsilateral cranial nerves and also non-adjacent, contralateral cranial nerves (8). Cerebellar signs range from ataxia and incoordination to dysmetria. Hemiparesis and/or hypesthesia convey evidence of long tract signs.

Other common conditions among the neurological deficits are pontomedullary abnormalities including dysphagia, dysphonia, dysarthria, facial weakness, and vertigo or dizziness (4). Diplopia or visual blurring, midbrain or combined midbrain-pontine symptoms, occur less frequently. Persistent, neurological sequelae develop in approximately 60% of survivors (8).

The neuropathy seen in this syndrome most likely occurs due to the invasion of brain parenchyma by *L. monocytogenes*, a non-acid-fast, gram positive bacillus (4,8). Entry into endothelial cells, important in the pathogenesis of central nervous system invasion, has been shown *in vitro* to occur primarily by two mechanisms – either direct invasion or through an intermediary phagocyte (10). Microscopic examination of the brainstem demonstrates hemorrhagic necrosis and suppurative inflammation, subacute abscesses, and involvement of the leptomenings (4,8).

Diagnostic tools helpful in the evaluation of *L. monocytogenes* rhomboencephalitis include CSF and blood samples as well as radiological evaluation. The initial, rare finding of gram positive rods in the CSF is valuable in antibiotic selection. CSF and blood cultures have been found positive in approximately 40% and 60% of the cases, respectively (4,8,9). MRI remains the optimal radiological tool and is more sensitive than contrast-enhanced CT in imaging lesions in the brainstem (5,8). MRI has been shown to demonstrate brainstem abscesses in approximately 85% of the cases studied (8).

The overall mortality rate of *L. monocytogenes* rhomboencephalitis has been shown to be 51% with all untreated patients dying (8). This mortality rate appears highly dependent upon the time frame of appropriate antibiotic initiation. Ampicillin, with or without the addition of gentamicin, is the drug of choice in the treatment of *L. monocytogenes* rhomboencephalitis (5,8). Resistance to ampicillin is rare (8). Survival rates greater than 75% have been shown when ampicillin or penicillin is used as the first-line agent (8). Antibiotic treatment should continue for four to six weeks (4,5).

Chloramphenicol has been used as an alternative antibiotic, but it should be avoided since at least one death has occurred when a patient was treated with only this agent (8). Trimethoprim/sulfamethoxazole has been demonstrated to be an acceptable alternative agent for listerial infections, including meningitis; however, studies utilizing this agent in patients with rhomboencephalitis are lacking (8). Cephalosporins lack efficacy in the treatment of listerial infections (4,8).

While *L. monocytogenes* rhomboencephalitis is not likely to be suspected during a typical, non-specific prodrome, it is vital to include this bacteria in the differential diagnosis upon the presentation of fever and neurological deficits with or without meningeal signs in both immunocompetent and immunosuppressed adults. Any focal neurological sign localized to the brainstem in an undetermined meningitis should prompt consideration of *L. monocytogenes* rhomboencephalitis. In this situation, the empiric antibiotic selection should include appropriate coverage for *L. monocytogenes*.

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Women's Health Issues: An Agenda for 1998 and Beyond

The West Virginia Chapter of the American College of Physicians Scientific Meeting is scheduled for April 30 - May 3, 1998 at Wilson Lodge at Oglebay Resort and Conference Center in Wheeling.

This year's theme, Women's Health Issues: An Agenda for 1998 and Beyond, was chosen because of the increasing importance of conditions affecting women, namely osteoporosis, breast cancer, and cardiovascular disease. These are areas of practice faced by all physicians, family practitioners, general internists and subspecialists. Special presentations include the different roles women physicians play in the care of their patients, and the use of complementary and alternative medicine.

An exciting part of this meeting will also include two unique programs for internal medicine residents at each of the four training centers in West Virginia. In addition to their research paper presentations, we will host a Medical Knowledge Challenge competition, modeled after "Jeopardy." The winning team will participate in the National Competition during the 1999 ACP meeting in New Orleans.

Plan to join us at this meeting and take advantage of the 13 Category I CME credits available for physicians who participate in the complete program. We have left ample time for your enjoyment of the beautiful facilities of Oglebay Park! A special guest program and other social activities have been added!
For registration information, contact the WV Chapter at (304) 242-7751 or fax us at (304) 242-7254.

American College of Physicians WV Chapter Scientific Meeting

Primary angioplasty in acute myocardial infarction: West Virginia University experience

ANURAG MEHTA, M.D.

ABNASH C. JAIN, M.D.

MAHAVEER MEHTA, M.D.

ANTHONY P. MORISE, M.D.

Section of Cardiology, Department of Medicine, West Virginia University School of Medicine, Morgantown

Abstract

Primary angioplasty is a useful alternate treatment to open the occluded coronary arteries during the acute phase of a myocardial infarction associated with ST segment elevation. We describe our experience with 50 patients seen at West Virginia University Hospital in Morgantown over a period of one year.

Introduction

Percutaneous coronary angioplasty as a treatment for coronary artery disease was first reported in 1976 (1). Since then, the indications for angioplasty have expanded to include both stable and unstable coronary syndromes. Now, immediate coronary angioplasty is being utilized as both the primary treatment for acute myocardial infarction (MI) and as an alternate to intravenous thrombolytic therapy (2,3,4).

This report reviews our experience treating 50 patients at West Virginia University Hospital with primary coronary artery angioplasty (PCA).

Materials and methods

We reviewed the treatment of 50 patients with acute Q wave MI with minimum ST-segment elevation of > 1 mm admitted to West Virginia University Hospital between September 1995 to September 1996. All patients were treated with primary PCA within 12 hours of the onset of ischemic chest pain.

Inclusion criteria for PCA were:

1. Contraindication to thrombolytic therapy;
2. Cardiogenic shock;
3. Advanced age;
4. Persistent tachycardia; and
5. Sustained hypotension.

Exclusion criteria for PCA were:

1. Inability to provide informed consent;
2. Dementia; and
3. Increased risk of bleeding.

According to the Thrombolysis in Myocardial Infarction (TIMI) research group (5), occluded arteries were graded as follows:

TIMI - 0 = no flow;
TIMI - 1 = dye penetrates clot without perfusion;
TIMI - 2 = full perfusion with slow flow;
TIMI - 3 = full perfusion with normal flow.

TIMI flow before and after PCA is shown in Table 1. Those patients where TIMI flow improved from 0 and 1 to grade 2 to 3 were classified as having successful PCA.

In addition to the TIMI flow before and after PCA, demographic data, creatine kinase (CK), CK-MB, CK index, length of hospital stay, costs, complications and in hospital mortality were recorded.

Procedural protocol

After obtaining their consent, patients were treated with oxygen, aspirin (325 mg), I.V. heparin (5,000 units) and I.V. nitroglycerin (5 ug/min), except in those with inferior-posterior wall infarctions).

Patients then underwent diagnostic coronary angiography and, if found suitable for primary PCA, were given abciximab (Reopro), a platelet 2b/3a receptor inhibitor, 0.25 mg/kg as an intravenous bolus followed by an infusion at 0.75 mg/hours for 12 hrs. This drug was administered to 40 (80%) of the patients. PCA was then performed using the standard guide wire balloon angioplasty method with an attempt to both restore flow

Table 1. TIMI flow before and after coronary artery angioplasty (PCA).

	TIMI - 0	TIMI - 1	TIMI - 2	TIMI - 3
Before - PCA	24 - (48%)	25 - (50%)	1 - (2%)	0 - (0%)
After - PCA	0 - (0%)	2 - (4%)	7 - (14%)	41 - (82%)

Table 2. The distribution of the infarction location in the 50 patients.

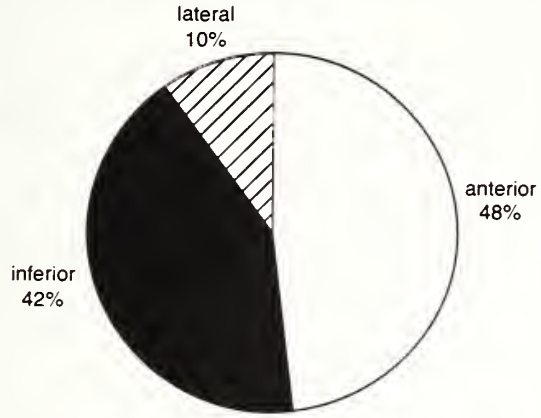

Table 3. The frequencies of risk factors in the patients treated with primary coronary angioplasty.

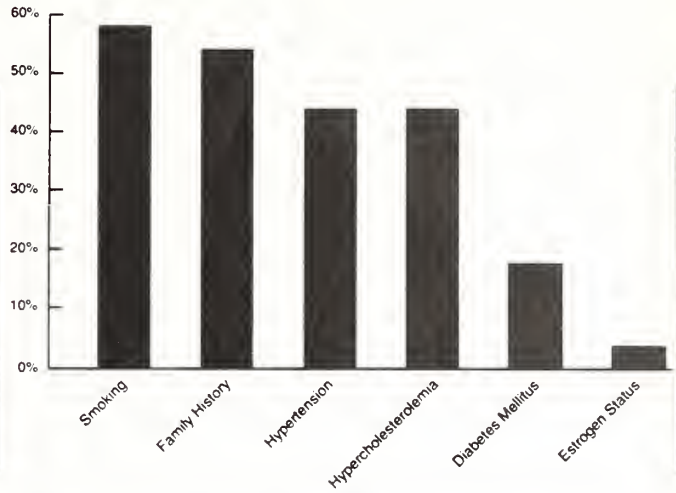

Figure 1. Right coronary angiogram (RCA) in left anterior oblique view showing the artery occluded with TIMI - 0. Arrow shows the site of preangioplasty.

Figure 2. Right coronary angiogram in left anterior oblique view showing the artery after angioplasty which opened it to TIMI - 3 flow.

and reduce the degree of stenosis to less than 25%. Following PCA, beta blockers and angiotensin converting enzyme inhibitors were given as per AHA/ACC (6) treatment guidelines for the treatment of MI.

Results

Fifty patients with acute Q wave MI were treated with primary PCA. This population included 14 females (28%) and four non-Caucasians (8%). The distribution of infarction location is shown in Figure 2, and Figure 3 displays the frequency of coronary risk factors.

Only two of the women had positive estrogen status and two of the men had a prior MI. The mean CK enzymes were total 1,830 $\pm$ 124; CK - MB 151 $\pm$ 33; CK index 12 $\pm$ 10.

TIMI grade 3 flow was reached in 41 of the patients (82%), TIMI 2 in 7 (14%), and TIMI 0 - 1 in 2 (4%) as shown in (Table 1). Figures 1 and 2 show examples of TIMI flow for grades 0 and 3.

These statistics show that the procedure was successful in 48 patients (96%). The complications of PCA include retroperitoneal hematoma in one patient, renal

failure (one patient), non-hemoragic stroke (one patient), ventricular fibrillation (one patient), atrial fibrillation (one patient), and minor arterial puncture site bleeding in three patients. In addition, three patients had to undergo coronary artery bypass surgery because of their deteriorating clinical status.

The mean hospital stay for the patients in our study was 4.5 ± 2 days with an average total cost procedural cost of $12,120 ± $2,500 (Physician fee $2,756 ± $720). There were no mortalities.

Discussion

Acute Q wave MI results from thrombotic occlusion of a coronary artery (7), and megatrials have concluded that I.V. thrombolytic therapy reduces mortality (8,9). The success of this therapy is limited by re-occlusion, complications from bleeding, difficulties in reperfusing all occluded coronary arteries, recurrent myocardial ischemia and contraindications to the therapy (2).

As a result, PCA was proposed as an alternate treatment to thrombolytic therapy for the treatment of acute Q wave MI. In March 1993, three reports appeared evaluating PCA in this setting using prospective randomized trials (2,3,10). Since these reports were published, there has been an increase in the use of PCA.

PCA is a viable alternate treatment if the patient has timely access to a facility with a catheterization laboratory as well as a trained interventionist. (Only 18% of cardiac catheterization labs in the U.S. can perform PCA.) The cost of the procedure has varied from between $14,772 to $23,500 (11), and patients who undergo PCA have shorter hospital stays (2,3) than those treated with thrombolytic therapy. The shorter hospital stay for our patients (mean 4.5 days) is very comparable to those described in various reports (2-4,10,11). The other advantage to PCA is that it provides the physician with coronary anatomy which is useful in assessing risks of subsequent coronary events and planning future treatment strategies.

Conclusion

Our initial results obtained with primary coronary artery angioplasty at WVU Hospital reveal a high success rate (96%). The use of Abciximab may have helped us achieve this high success rate, especially concerning reocclusion.

We conclude that the treatment of acute MI by PCA is a useful alternate treatment to thrombolytic therapy that has advantages over thrombolysis. However, its widespread use is limited due to the need for specialized facilities and expertise, as well as the need to provide reperfusion therapy as quickly as possible in many patients who live in areas far away from appropriate facilities.

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(Please contact author for other references listed in this manuscript.)

Axillary vien thrombosis during pregnancy in association with a lupus anticoagulant

GREGORY DOYLE, M.D.
Associate Professor, Department of Family Medicine, West Virginia University School of Medicine, Morgantown

MILLARD SIMMONS, M.D.
Professor, Department of Obstetrics and Gynecology, West Virginia University School of Medicine, Morgantown

KENNETH GRANKE, M.D.
Associate Professor, Department of Vascular Surgery, West Virginia University School of Medicine, Morgantown

Abstract

A 42-year-old multiparous pregnant woman presented with swelling and pain of the left arm at 34 weeks gestation. She had no discoloration of her arm nor a loss of radial pulse. Duplex scanning demonstrated a thrombosis in the axillary vein. She was found to have a positive circulating lupus anticoagulant. Intravenous heparin was administered and resulted in resolution of discomfort and swelling on day four of therapy. The patient was maintained on therapeutic doses of subcutaneous heparin until vaginal delivery at 39 weeks. Prenatal course was complicated by a resolving infection believed to be due to cat-scratch disease which produced a five centimeter cystic lesion in the left axillae which was removed in the first trimester. Titers for cat-scratch disease were positive for mother and infant at delivery but infant titers were negative at six weeks. Axillary vein thrombosis in pregnancy can be complicated by pulmonary embolism and should be treated by heparin.

Introduction

Axillary vein thrombosis during pregnancy has been reported only three times in the English language literature: in a Scottish woman with a familial antithrombin III deficiency (1); in association with a molar pregnancy in the 12th week (2); and in a 32-year-old multiparous woman in which no etiology was found (3).

We describe a 42-year-old multiparous woman with axillary vein thrombosis diagnosed at 34 weeks, who was found to have a circulating lupus anticoagulant.

Case report

A 42-year-old woman, gravida 3, para 1 was seen in the Family Medicine Clinic at 34 weeks gestation. She had noted mild swelling and pain of the left hand for one and two weeks, respectively, prior to presentation.

This patient denied fever or other systemic symptoms. There was no personal or family history of clotting disorders or thrombosis in pregnancy. Several months prior to the current pregnancy, while living in Atlanta, she had developed a cystic swelling in her left axilla and a presumptive diagnosis of cat-scratch disease was made. The contents of the cyst were aspirated, but cytologic examination including silver staining was not diagnostic of cat-scratch disease and no other cause for the mass was determined. Later, during the first trimester of her current pregnancy, a large residual cyst was removed from the same axillary site under local anesthesia.

On admission, vital signs were normal except for a mild increase in systolic blood pressure which abated with bed rest. The patient's left hand was edematous but not cyanotic or cold, and a radial pulse was palpable. The left upper arm circumference was only 0.7 cm. larger than the right arm. There was tenderness in the left axilla but not along the upper arm. The lung, heart, and lower extremity exams were unremarkable.

Admission labs included a hemoglobin of 12.9 grams, WBC count 9,300/cu. mm., and platelet count 227,000/cu. mm. The partial tissue thromboplastin time (PTT) was 30 sec. (normal 23.5-31), and the fibrinogen level was normal. A serum assay for circulating lupus anticoagulant was positive.

Electrocardiography did not reveal sinus tachycardia, right axis shift or non-specific T-wave inversion. The patient was not short of breath and pulmonary embolism was not suspected. Tests for anti-nuclear antibody and rheumatoid factor were negative. Serum level of antithrombin III was within the normal range.

Duplex ultrasonography showed an axillary vein thrombosis of undetermined age, but was felt to be of an acute and chronic nature. The subclavian vein was examined sonographically on two occasions and felt to be free of clot. Obstetrical and vascular surgery consultations were obtained. In view of the hypercoagulable pregnant state and the circulating lupus anticoagulant, anticoagulation was recommended.

This patient responded to I.V. heparin (5,000 units bolus, followed by 1,300 units/hr. to maintain the PTT at one and one-half times normal) with resolution of hand swelling by her fourth day in the hospital. Subcutaneous (sc) heparin was begun the next day, and she was discharged on day seven fully anticoagulated with PTT one and one-half to two times normal. This treatment was continued throughout the remainder of her pregnancy.

At 39 weeks gestation, she vaginally delivered a 3288 gm. baby girl. Heparin was discontinued 14

hours before delivery; warfarin was substituted on her second postpartum day and continued for 12 weeks. Using an indirect immunofluorescent antibody technique, recently made available at the Centers for Disease Control and Prevention on an investigative basis, antibodies vs. Rochlimaea henselae and R. quintana were detectable in both maternal serum (1:64 and 1:128, respectively) and cord blood (1:256 and 1:512, respectively).

At four weeks follow-up, both mother and infant were doing well and were asymptomatic. The lupus anticoagulant of the mother on recheck was negative. At six weeks postpartum, the mother's titers for Rochlimaea henselae and R. quintana were still positive yet the infant's were negative suggesting passive transfer of antibody via placenta. Duplex scanning of the axillary vein at 12 weeks postpartum was normal. The mother's protein S and C levels obtained off coumadin were within the normal range.

Table 1. Etiologies of axillary-subclavian vein thrombosis.

A. Iatrogenic

Central venous catheters; permanent central vein or right catheters (e.g. Hickman); transvenous pacemakers; venous catheterization.

B. Traumatic

Local trauma to the upper extremities; exertional or physical effort (producing endothelial injury); axillary hematomas; axillary or subclavian vein injury.

C. Hypercoagulability

Antithrombin III deficiency; lupus coagulant; pregnancy; malignancy (e.g. colon, lung, or ovarian); malignant lymph nodes (primary or metastatic).

D. Anatomic defects

(e.g. cervical ribs and subclavian stenosis).

E. Post-treatment

Status/post radical neck surgery, radiation, or radical mastectomy.

F. Other

Congestive heart failure; axillary artery aneurysms; I.V. drug use, especially cocaine.

Discussion

Only 2% of the cases of deep venous thrombosis are found in the axillary vein (5). Conditions to be distinguished from axillary vein thrombosis during pregnancy include local allergic reactions, infections of upper extremity soft tissues, bones, and joints, postoperative edema following axillary and breast surgery, unnoticed trauma and lymphoproliferative disease (2).

Axillary vein thrombosis is uncommonly detected in pregnancy, with this case representing only the fourth reported in the English literature. Thrombosis of the axillary vein has become an increasingly frequent occurrence in patients undergoing central venous catheterization, but multiple other etiologies have been implicated (3,5,6,7,8) (Table 1). In two of the three previously reported cases occurring during pregnancy, complicating factors were present. One patient had an antithrombin III deficiency (1), and another had a molar pregnancy (2). The third case had no known associated risk factors and the thrombosis was considered to be idiopathic in etiology (3). Ours is the first reported case with a positive lupus anticoagulant. Previous cat-scratch infection involving the axilla, suggested by serologic antibody titers to Rochalimaea species at the time of delivery, and axillary surgery performed during the first trimester may also have contributed to axillary vein thrombosis.

Doppler ultrasonography and to a lesser extent impedance plethysmography represent acceptable, non-invasive alternatives to contrast venography, although both modalities are less sensitive than venograms (8,9,10). Duplex scanning has a sensitivity of 89% and a specificity of 100% (10). Its clinical usefulness was shown in our patient.

Follow-up duplex scans can be performed in pregnancy, if needed, without exposing the mother or fetus to ionizing radiation. Venography remains the gold standard, however, and it may be indicated in high-risk pregnant patients with negative duplex scans and a high clinical suspicion (10).

Treatment approaches to axillary and subclavian venous thrombosis vary and include conservative management, anticoagulation, thrombolytic therapy, and surgery (11). The risk of heparinization is small, with about 5% to 10% of patients experiencing bleeding, and only half of these being serious bleeds (12). Other adverse effects of heparin during pregnancy include osteoporosis (1%-3%) and thrombocytopenia (1%).

The risk of pulmonary embolism is unknown when axillary thrombosis occurs during pregnancy. Pulmonary embolism complicating axillary subclavian thrombosis not associated with pregnancy may occur in up to 12% of cases (4,11). In lower limb thrombophlebitis of pregnancy, I.V. heparinization has resulted in a 32% decrease in the incidence of pulmonary embolism,

and an 18-fold decrease in mortality when compared to untreated subjects (12). Anticoagulation also has been shown to improve the long-term disability if administered within the first week of symptoms.

Thrombolytic therapy has been used, in the past, with either streptokinase or urokinase. Assessment of the results in this approach is hampered by the fact that spontaneous recanalization occurs in the absence of any thrombolytic drugs.

When veins are thrombectomized operatively, the late patency is low. Damage is thought to occur with direct trauma to the vein wall. It may be best to consider surgical thrombectomy in only the extremely swollen extremity or in patients with non-thrombotic subclavian vein obstruction. Otherwise, heparinization and elevation, avoiding the hyperabducted position would be the favored initial treatment.

Recent reports of thrombolytic therapy have been associated with early revascularization, but the incidence of late patency of the axillary vein is uncertain (11). Effort thrombosis in the non-pregnant patient may be a notable exception with evidence of long-term patency in a recent report (13). When considering risks versus benefits, thrombolytic therapy is probably a less desirable alternative to heparin anticoagulation for upper extremity thrombophlebitis in pregnancy because of the risks of intracranial bleeding, anaphylactic shock, and abruptio placentae (3,5,11).

Late reconstruction of the veins is beneficial to selected patients with debilitating symptoms when collateral developments have proven to be insufficient (14). Surgery or recent advances in percutaneous techniques with balloon angioplasty or stent placement may also be indicated if an anatomic defect, such as an axillary or subclavian stenosis or cervical rib is identified. Venography can help delineate such anatomic defects prior to surgery (11). Long-term anticoagulation would only be beneficial in proven cases of a persistant hypercoagulable state.

Acknowledgement

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Bacteremia due to streptococcus zooepidemicus associated with an abdominal aortic aneurysm

CESAR ALBARRACIN, M.D.
Internal Medicine Specialist, Corpus Christi, Texas; Former Resident, Department of Medicine, West Virginia University School of Medicine, Charleston Division

GREGORY ROSENCRANCE, M.D.
Associate Professor and Assistant Chairman, Department of Medicine, West Virginia University School of Medicine, Charleston Division

JAMES BOLAND, M.D.
Professor and Chairman, Department of Surgery, West Virginia University School of Medicine, Charleston Division

JAIME E. HERNANDEZ, M.D.
Assistant Professor of Medicine, Section of Infectious Diseases, West Virginia University School of Medicine, Charleston Division

Abstract

Group C streptococci are a common cause of infection in animals but a rare cause of infection in man. To our knowledge, the English literature contains only three cases of arteriosclerotic aneurysms of the abdominal aorta (AAA) secondarily infected with group C Beta-hemolytic Streptococci. Two cases did not survive in spite of adequate antibiotic therapy. One patient responded to aortic repair with a bifurcated woven dacron graft followed by four weeks of high-dose intravenous penicillin. This article describes our clinical experience with a patient who survived an atherosclerotic aneurysm of the abdominal aorta and S. zooepidemicus infection.

Introduction

The most common organisms associated with secondarily infected arteriosclerotic abdominal aneurysms are *Salmonella sp.* followed by *Staphylococcus sp.* (1). Species of streptococci have rarely been implicated.

In a study by Bradley et al of 88 patients with group C streptococcal bacteremia, manifestations of group C streptococcal infection were associated with intravascular infection and with endocarditis (2). There was only one case of an aneurysm of the abdominal aorta with secondary infection due to group C Beta-hemolytic Streptococci (3). A report from Hong Kong (4) describes two patients with group C streptococcus infection of abdominal aortic aneurysms. Both of these patients underwent surgery with aortic repair followed by long-term IV antibiotics, but only one patient survived.

S. zooepidemicus is reported to be an uncommon human pathogen. Recent outbreaks of severe infection in people consuming unpasteurized milk and dairy products and presenting with septic arthritis, pneumonia, septicemia, post-streptococcal glomerulonephritis or meningitis have been described (5,6).

S. zooepidemicus ferments sorbitol but not threalose. It produces a novel hemolysis but not streptolysin O or S, does not produce streptokinase, and is not considered part of the normal flora in humans. Frequent, often epidemic infection occurs in domestic animals such as horses, cattle, goats, birds, monkeys, sheep, and pigs. Pneumonitis, septicemia, and abscesses are common manifestations of infection in animals.

This organism is the most aggressive human pathogen in the Lancefield group C but is susceptible to penicillin.

Case report

A 73-year-old white male came to the ER complaining of swelling in the lower part of his abdomen accompanied by fever, chills and nausea for the previous 10 days. He had been seen several days prior to admission and diagnosed with pyelonephritis. Ciprofloxacin had been started without improvement.

This patient denied any contact with farm animals. His only possible exposure was a laceration on his right hand that had come in contact with bat droppings in his basement two weeks before his admission to the hospital. Previous operations included herniorrhaphy and trans-urethral resection of the prostate. He was allergic to codeine and tetanus vaccine.

On examination, his temperature was 37.1°C., blood pressure 96/64 mm/Hg, pulse 80 per minute. The lungs were clear and the cardiac examination showed atrial fibrillation. The abdomen was tender over the hypogastrium and bowel sounds were present. The right hand had a small erythematous nodule over the second proximal interphalangeal joint with a small scratch in the skin.

This patient had a white count of 26,400/mm^3 with a differential of 78% polymorphonuclear leukocytes, 10% band forms, 6% lymphocytes and 6% monocytes. The erythrocyte sedimentation rate was 51 mm and 2 blood cultures were positive for Beta streptococcus group C (*Streptococcus zooepidemicus*).

This patient was started on I.V. antibiotics when he was admitted, but he continued having abdominal pain with radiation to his lower back and persistent fever. A CT scan of the abdomen revealed a 6.3 cm infrarenal abdominal aortic aneurysm (Figure 1). A labeled white blood cell scan showed increased uptake over the abdominal aorta (Figure 2).

Figure 1. CT scan revealing a 6.3 cm infrarenal abdominal aortic aneursym.

Figure 2. A labeled white blood cell scan which shows increased uptake over the abdominal aorta.

He was taken to surgery and an aorto-iliac graft was placed after aneurysm resection. I.V. antibiotics were continued and he had a slow recovery. He was discharged from the hospital eight weeks later.

Pathology reports confirmed the presence of microabscesses in the aortic wall. He completed 4 weeks of intravenous penicillin G and remains without signs of recurrence after 14 months of follow-up.

Discussion

This case highlights the emerging role of group C streptococcus as an opportunistic pathogen. Historically, it has been a rare infection, but since 1979 there have been 20 reported cases (Case Western Reserve).

Infections associated with group C streptococcus were first described as endocarditis, site-specific infections (meningitis) and bacteremia. Salata et al reported other manifestations such as polymicrobial infections, intra-abdominal abscesses, epidural abscesses and dialysis associated infections (8). It is not known whether this increasing incidence is due to more frequent infections or to improvements in microbiologic techniques.

In most cases, it is difficult to document previous exposure to animals or their droppings, and the clinical features are non-specific. An increased number of band cells is the only common feature. Bacteremia has usually been reported in association with leukemia, cancer or immunosuppression. Several aspects are noteworthy in our patient's case in which persistent bacteremia and back pain led to suspicion of an infected AAA and early intervention. A CT scan of the abdomen and WBC scan were helpful in making the diagnosis as previously described by Ben-Haim et al (9).

To our knowledge, this is only the second case of a mycotic aneurysm due to *Streptococcus zooepidemicus* that survived after surgical resection and long-term intravenous penicillin G. Clinical suspicion and early intervention contributed to the good outcome in the first case; an abdominal CT scan and labeled WBC scan were not done. Bacterial infection of the aorta is considered a vascular catastrophe since mortality rates exceed 50% in many series. Optimal management includes debridement of all localized aortic and periaortic infectious processes, *in situ* aortic reconstruction, and extended use of I.V. antibiotics (minimum 10-14 days) followed by long-term suppression with oral antibiotics (at least 6 weeks) (10).

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Adoption: From chaos to normalcy

TIMOTHY LESACA, M.D.
Clinical Assistant Professor of Psychiatry, Medical College of Pennsylvania, Staunton Clinic, Sewickly, Pa.

Abstract

This article acknowledges the risk factors and psychological demands of the adopted child and adoptive parents. Despite many biologic and psychosocial obstacles, most adoptions are considered successful because most of the adopted children do not encounter long-term psychological difficulties.

Introduction

Although adoption dates back centuries, the issue of whether or not adopted children are at risk for psychological maladjustment remains unresolved. That this dispute would occur at all is not surprising, since as recently as 1926 laws which liberalized adoptions in England were faced with a widespread objection that adoption would encourage depraved conduct (1,2).

The purpose of this article is to acknowledge both the realities and misconceptions of adoption and psychological maladjustment. Preadoption risk factors, emotional challenges of adoptive childhood and parenthood, and outcome studies on adoption are described.

Preadoption risk factors

Adopted children are exposed to many stressors that could increase their risks for psychological maladjustment. Individuals who give their children up for adoption have a high incidence of impulse control problems such as hyperkinesis, chemical dependency, and personality disorder. Therefore, adopted children are at genetic risk for these disorders. Also, unmarried women who become pregnant and give up their children for adoption often fail to seek prenatal care and are at risk of giving birth to premature and low birth weight infants. (3,4)

Before a permanent adoption occurs, children often endure poor nutrition and health, poor living conditions, discontinuous care taking, disharmonious family environments, inadequate stimulation and lack of affection, neglect, and abuse (1). A study of foreign adopted children by Verhulst and colleagues found 45% experienced neglect, 13% were abused, 54% experienced at least one change in caretakers, 6% experienced three or more caretaking environments, and 43% were in poor physical health (5).

Challenges for children

Adoptive children face obstacles that do not cease after the formal adoption process has occurred. Children must confront the difficult questions of whom their biologic parents are and why they are no longer with them. Adopted children sometimes think they were somehow unacceptable to their biologic parents and feel abandoned. This rationalization can lead to low self esteem and fear of future abandonment (6).

Adopted children are naturally inquisitive about their own backgrounds and that of their biologic families. Unfortunately, they have a double hindrance in this regard, as they usually find it difficult to find their personal histories, and are likely to have feelings of ambivalence and anxiety about what they might discover (7).

Unresolved questions about their backgrounds can lead to obstacles in healthy identity formation. A strong identification with an idealized image of their biologic parents sometimes fills the emotional void resulting from these lingering uncertainties. Identification with the idealized biologic parents can compel the adopted child to reject and devalue their adoptive parents, which complicates the process of identity formation (8).

Challenges for parents

Adoptive parenthood involves difficult challenges as well. Adoptive parents must resolve the grief for the wished-for biologic child and come to terms with infertility issues. Anger directed toward the spouse held accountable for the inability or the choice not to conceive can taint a couple's relationship.

Insufficient emotional acceptance of the adoption alternative may result in a romanticized image of the biologic child who might have been. Failure to work through the

loss of the biologic child can lead to feelings of rejection, alienation, entitlement, and misdirected anger toward the adopted child, particularly if he or she fails to meet the parent's expectations (9,10).

Some adoptive parents also find themselves having negative dreams and thoughts about the biologic parents that they become overly concerned about the adopted child's behaviors. These concerns can lead to a prohibitive attitude toward developmentally normal sexual and aggressive childhood activities. The resulting scrutiny by the parents can convey to the child that they have a negative and antisocial image of him or her (11).

Outcomes of adoption

Several factors have been associated with increased risk of psychological maladjustment in adoptees. In the previously mentioned study of foreign adoptees by Verhulst et al, problem behaviors were seen in 24% of the children who had been severely neglected, in 31% of the severely abused children, and in 50% of the children who had experienced at least five changes in caretaking environments (5).

The child's age at placement has also been shown to affect outcome since better psychological adaptation is associated with adoption during the first six months of age. Studies usually conclude that the earlier the placement of the child, the better the outcome. Adoption at a young age is thought to spare the child many adverse life experiences such as several temporary placements and changes in caretakers. In addition, older children may have habits and behaviors which are difficult for parents (3,5,12).

Interestingly, transracial adoption has not been found a risk factor for psychological maladjustment. In a study of transracially adopted black children in the U.S., McRoy et al found no difference in overall self-esteem between transracially and intraracially adopted children. The self-esteem of the transracial adoptees was as high as that reported among individuals in the general population (13).

Studies show that adopted children present more frequently for both inpatient and outpatient psychiatric treatment compared with the proportion of "natural children" in the general population. The proportion of adopted children in psychiatric treatment settings ranges from 2.4% to 17% (4). Despite their higher propensity for presenting to psychiatric treatment, the actual incidence of psychiatric illness in adopted children has not been found higher than the incidence in the general population, except for hyperkinesis in adopted boys. In fact, adopted children do not differ from non-adopted children in the incidence of educational problems or substance abuse (14,15).

Other recent studies also show that there is no support for the commonly held belief that adopted children appear more often in psychiatric settings because they are more troubled. Adoptive families have until recently been largely from socioeconomic strata at or above the median, thus allowing for more access to psychiatric care. Additionally, most adoptions in the U.S. are accomplished through agencies that attempt to provide many support services such as mental health consultation. Finally, the adoptive family might see the adoptee as at increased risk for problems and may more quickly identify even minor difficulties as warranting treatment (12,16).

Despite the risks and challenges of adoption, the vast majority of adoptees do not manifest long-term problems, nor do they require psychiatric treatment (12). Bohman and colleagues followed a cohort of adopted children through adulthood and found that adopted boys had increased difficulties compared with non-adopted boys at 10 and 11 years old, but that few differences were found from 15 years of age onward (17). This suggests that the adverse effects of early life events can be offset by the adaptive capability of the mind and the positive influences of the adoptive family (5).

Conclusion

Adopted children and adoptive families are faced with many perils and difficulties. Despite the challenges that arise from working through adoption related issues, most adopted children adjust well. We must be mindful, however, that being a member of an adopted family is a complex reality with which to come to terms, and individuals assimilate that reality in different ways and with varying degrees of mastery.

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Annual Meeting schedule changed to original format; First Session to be held on Wednesday

This year's Annual Meeting features a schedule which moves the First Session of the House of Delegates to the first day of the conference, Wednesday, August 26. This First Session will start at 1:30 p.m. after the Council Meeting at 9 a.m. and the Executive Committee/Council/ Component Society Presidents' Luncheon at 11:30 p.m.

This format, which was last utilized in 1992, has been revised so **Nancy W. Dickey, M.D.**, who will be the president of the AMA, can present her address on Wednesday, August 26 before having to leave to attend the AMA's Board of Trustees Meeting.

Following Dr. Dickey's address, **Alden H. Harken, M.D.**, professor of surgery and chairman of the Department of Surgery at the University of Colorado, will deliver the Thomas L. Harris Address which is entitled *"Anyone Can Treat Cardiac Arrhythmias."* In addition, **Thomas H. Chang, M.D.**, WVSMA president, will deliver his farewell address during this session.

Bios on Drs. Dickey and Harken begin below. A preliminary program for this year's Annual Meeting and a registration form are published in this issue beginning on page 100. For more meeting details, phone the WVSMA at (304) 925-0342.

Dickey

Harken

Chang

AMA president highlighted

Dr. Dickey is a board-certified family physician from College Station, Texas, who was elected president-elect of the AMA in June 1997. Prior to her election, Dr. Dickey served as chair of the AMA's Board of Trustees from November 1995 to June 1997, and as its vice chair form 1994-95.

First elected to the AMA Board of Trustees in 1989, Dr. Dickey served as secretary-treasurer from 1993-94 and as a member of the Board's Executive Committee since 1991. From 1993-94, Dr. Dickey chaired the AMA's Ad Hoc Technical Advisory Committee on Health System Reform and from 1992-94, she chaired the Finance Committee. In addition, she has served in a number of other roles for the AMA, including being commissioner for the Joint Commission on Accreditation of Healthcare Organizations from 1989 through 1995.

A fellow of the American Academy of Family Physicians, Dr. Dickey was vice president of the Texas Medical Association from 1986-87, and served as a delegate to the Texas Medical Association from Fort Bend County Medical Association from 1984-89.

A graduate of the Stephen F. Austin State University, she received her medical training at the University of Texas Medical School at Houston, where she was a recipient of the Distinguished Alumni Award. She currently serves on the editorial board of *Archives of Family Medicine* and has been a reviewer for the *Journal of the American Medical Association* and on the editorial advisory boards of *Patient Care, Medical World News* and *Medical Ethics Advisor.*

Thomas L. Harris lecturer

Dr. Harken was born in Boston and attended Harvard University and received his medical degree from Case-Western Reserve Medical School in 1976. After interning and serving as a junior resident in surgery at Peter Bent Brigham Hospital in Boston, Dr. Harken served as chief resident in cardiovascular surgery at Children's Hospital in Boston for a year and then returned to Peter Bent Brigham as the senior and chief resident in surgery.

In 1973, Dr. Harken became an investigator at the Walter Reed Army Institute of Research in Washington, D.C., where he also later served as chief of cardiovascular physiology. From 1976-83, Dr. Harken taught at the University of Pennsylvania in Philadelphia, during which time he

also was a staff attending physician at Veterans Administration Hospital in Philadelphia.

In 1984, Dr. Harken relocated to Denver to accept his current posts as professor of surgery and chairman of the Department of Surgery at the University of Colorado. He also serves as a staff surgeon at the University of Colorado Hospital, the Veterans Administration Hospital, and Rose Medical Center in Denver.

A diplomate of the National Board of Medical Examiners, Dr. Harken is certified by the American Board of Surgery and the American Board of Thoracic Surgery. He is the author of several books and has written over 350 scientific articles. Dr. Harken is on the editorial boards for the *Journal of Surgical Research*, *Journal of Cardiac Surgery*, *Archives of Surgery* and *Shock*.

At Annual Meeting

Lung reduction, diabetes care, genes, congestive failure, four topics for First General Session

Four lectures will be featured during the First General Scientific Session on Thursday, August 27 at 8:30 a.m. during this year's WVSMA Annual Meeting at The Greenbrier.

Robert J. Keenan, M.D., an assistant professor of surgery at the University of Pittsburgh, will kickoff this session with a talk on *"Lung Reduction."* Following this lecture, **Frank L. Schwartz, M.D., F.A.C.E.**, who specializes in endocrinology and metabolism in Parkersburg, will discuss *"Diabetes Care in the New Millenium: Will You Be An Evangelist or an Ostrich?*

After a short break, this session will reconvene with the lecture *"Genes Don't Count"* by **Alden H. Harken, M.D.**, professor of surgery and chairman of the Department of Surgery at the University of Colorado. Dr. Harken will also be delivering this year's Thomas L. Harris Address on Wednesday, August 26 which is entitled *"Anyone Can Treat Cardiac Arrhythmias."* This session will then conclude with a lecture entitled *"Congestive Failure 1998"* by **David L. Pearle, M.D.**, director of the Georgetown Heart Failure Service at Georgetown University Hospital in Washington, D.C.

A brief bio on Dr. Harken appears on the opposite page and bios on the other three speakers begin at the right. A preliminary program and a registration form for the meeting are published starting on page 100. Futher details about this year's meeting can be obtained by phoning the WVSMA at (304) 925-0342.

Keenan

Schwartz

Harken

Pearle

Speakers highlighted

Dr. Keenan received his M.D. degree from the University of Alberta in Edmonton in 1984 and then completed a mixed surgical internship at St. Michael's Hospital in Toronto. He remained in Toronto from 1985-89 for residencies in general surgery at the University of Toronto and at Mount Sinai Hospital.

After relocating to Pittsburgh in 1989 to become a research fellow in the Division of Cardiothoracic Surgery at the University of Pittsburgh, Dr. Keenan returned to the University of Toronto in 1991 to be the chief resident in thoracic surgery. Since 1992, Dr. Keenan has held his current posts as an assistant professor of surgery and director of the Lung Transplant Program at the University of Pittsburgh.

A fellow of the Royal College of Surgeons of Canada and a diplomate of the American Board of Surgery, Dr. Keen is currently conducting four research projects on grants from the National Cancer Institute, the National Institutes of Health and the Cancer Treatment Research Foundation.

Dr. Schwartz was born in Marietta, Ohio and received his M.D. degree from West Virginia University School of Medicine in 1978, where he also was a special graduate student in the Department of Pharmacology from 1973-78. He remained at WVU for an internship and residency in internal medicine, and completed two fellowships in the Division of Endocrinology and Metabolism.

In addition to his practice in endocrinology and metabolism with Endocrine Diagnostics, Inc., in Parkersburg, Dr. Schwartz is medical director of the Diabetes Management Center at Camden-Clark Memorial Hospital. He is also on the staffs of St. Joseph's Hospital, Health South Rehabilitation Hospital, Marietta Memorial Hospital, and Selby General Hospital.

Dr. Schwartz was named Clinician of the Year by the West Virginia Affiliate of the American Diabetes Association for 1991-92. A fellow of

the American College of Endocrinology, Dr. Schwartz is a charter member of the American Association of Clinical Endocrinology and a member of many other professional organizations. He is a clinical associate professor of medicine and pharmacology at the WVU School of Medicine.

Dr. Pearle obtained his M.D. degree from Harvard Medical School in 1968 and then completed an internship and residency in medicine at New York Hospital.

Following his residency, Dr. Pearle became a commissioned officer with the Public Health Service from 1970-72, and was a clinical instructor of medicine at George Washington University Hospital in Washington, D.C. In 1972, he was named a cardiology fellow at Georgetown University Hospital, and two years later he became a hemodynamics fellow at Washington Veterans Administration Hospital, where he also worked briefly as a staff cardiologist.

Since 1975, Dr. Pearle has been on the faculty at Georgetown University Hospital, where he currently serves as director of the Georgetown Heart Failure Service and director of the Coronary Care Unit. A fellow of the American College of Cardiology, the American Heart Association, the American College of Physicians and the Society for Cardiac Angiography, Dr. Pearle is also a member of the Intersociety Commission for Heart Disease Resources, the American Federation for Clinical Research and the Medical Society of the District of Columbia.

Dr. Pearle has written over 40 articles for journals and is presently working on a number of pharmaceutical research projects.

Call issued for surgical research papers

The Academy of Surgical Research has issued a call for papers for its 14th annual meeting, which will take place in Nashville October 1-3.

For more details, phone the Academy at (612) 927-6707.

Experts see turbulence in medical malpractice market

The tidal wave of problems flowing out of the demise of PIE Mutual continues to swamp that industry and worry physicians. PIE Mutual, once West Virginia's largest writer of malpractice insurance, was recently taken over by Ohio regulators and physicians are being warned to evaluate their carriers closely.

An article in the February 16th issue of the *American Medical News* entitled *"Market upheaval threatens liability rate hikes,"* focuses on the dramatic shakeup in medical malpractice. The article quotes Nancy E. Carini of Conning & Co., warning physicians about malpractice insurers selling coverage at any cost. She says that some carriers are going to get business at any cost, with dangerous consequences.

Another expert warns that coverage is being sold "at less than what it costs to provide at a time when theories of liability are expanding exponentially. Those trends are completely incompatible."

The article also points out that many companies which recently entered the med mal market with cut-rate premiums are finding that rising losses and high price claims may mean the honeymoon is over. They may either raise rates dramatically in an effort to catch up, exit the market or simple fail; none of which bodes well for physicians.

The *AMN* article also takes note of the recent troubles faced by PIE Mutual and its insureds as an example of what can happen after years of inadequate pricing. The WVSMA's endorsed carrier, Medical Assurance, is a leader in the industry and has long been recognized for its financial strength and stable, long-term approach to this volatile line of insurance coverage. In fact, Standard & Poor's has recently upgraded Medical Assurance to A+ in recognition of its superlative financial condition.

Clearly, there are sensible alternatives in the medical malpractice insurance marketplace. But insurance experts warn that physicians who choose to buy their coverage based on low price alone are likely to face a rough ride as the turbulence in the medical malpractice market grows.

For a copy of the *AMN* article, phone Misty Ramsey at the WVSMA at (800) 257-4747 or (304) 925-0342. For more information about the WVSMA's endorsed carrier, Medical Assurance, phone Steve Brown at (800) 331-6298 or (304) 346-8228.

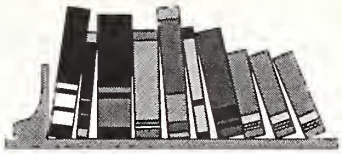
More organ donors needed in West Virginia

For the first time in two years, the percentage of West Virginia residents consenting to donation has dipped below 50 percent, in sharp contrast to the number of residents who apparently support donation.

The Center for Organ Recovery & Education (CORE) is encouraging physicians to make referrals to help increase the number of individuals donating organs. If the death of a patient is imminent or has been declared, a physician or his/her designee should immediately notify CORE. Referrals to CORE should be made prior to disconnecting a ventilator and before mentioning anything to the family about donation or contacting a funeral home. CORE then will work to determine suitability for donation based on feedback gained through the referral.

For more information, please call CORE at 1-800-366-6777.

Book Review



Medical Warrior: Fighting Corporate Socialized Medicine

By: Miguel A. Faria Jr., M.D.

"They that give up essential liberty to obtain temporary safety deserve neither liberty nor safety."

Benjamin Franklin

"The hottest place in hell is reserved for those who in time of crisis profess their neutrality."

Dante Alighieri

READ THIS BOOK! Whether or not you agree with the philosophy of the author, the well-reasoned insights into the problems facing physicians today makes this book worth the read. If you have felt beleaguered by the rapidly changing "health care delivery system" the past several years, this collection of essays by Dr. Miguel Faria Jr., will help provide a framework for understanding the forces reshaping the practice of medicine in America.

Beginning with the historical perspective which Dr. Faria developed in his book, *Vandals at the Gates of Medicine - Historic Perspectives on the Battle Over Health Care Reform,* he traces the path, during the past 30 years, from the start of government involvement in medicine with the passage of Medicare and Medicaid in 1965 to our present managed care/managed competition system. He interweaves descriptions of the other concurrent changes in society during these years, such as the problems in the criminal justice system, the rise in the use of lawsuits to resolve disputes and redistribute wealth, and the destruction of the family by welfare policies.

Dr. Faria then reaches back in history for parallels to illustrate the probable results of these changes, with many examples taken from the bureaucratic intrusions into medicine and other professions in the declining years of the Roman Empire leading to the Dark Ages of medieval society. He details the decline and ultimate disappearance of the medical profession in Babylonia due to the severe penalties and criminalization of failure to cure disease under the Code of Hammurabi.

Dr. Faria confronts the front-page issues of the past several years and, while several of the editorials written during the Clinton health care reform effort appear dated, they contain factual, footnoted rebuttals about charges of soaring medical costs (physicians fees have remained stable at 19% of total health care expenditures since 1950), high perinatal mortality (we have high rates of low-birth weight and premature babies due to teen pregnancy, drug use, alcoholism, smoking, etc.), and the uninsured (only 4% of the public lacks health insurance for 2 years or more). He challenges the assumptions of global warming and the criminalization of wetlands regulations.

The politicization of child abuse and the government's intrusion into the family are also discussed by the author. In addition, he explores the privacy and civil rights issues raised by the National Practitioners Data Bank; the question of health care as a right in terms of the Constitution and the Bill of Rights; the role of public health services and the CDC in AIDS and in gun control; and whether the mandates of managed care are forcing physicians into veterinary ethics.

Interestingly, the author invites readers to reread Ayn Rand's novel *Atlas Shrugged,* with its powerful, government-appointed Unification Board intruding into all aspects of life and work, as a prophetic glimpse of the future that America is headed towards if we continue on the current path of more and more government intervention in our lives. His essays are each prefaced by quotes ranging from the ancient philosophers to our founding fathers and from presidents to Woody Allen.

His solutions for medicine's problems? - the consumer-oriented free-market approach of Medical Savings Accounts and the absolute sanctity of the physician-patient relationship. He concludes with essays detailing his dismissal as editor of the *Journal of the Medical Association of Georgia* because he dared to address these controversial topics and other "sacred cows." However, his dismissal also led to opportunity because Dr. Faria is now editor of the *Medical Sentinel,* the journal of the Association of American Physicians and Surgeons.

All-in-all, an engaging, thought-provoking, and quite readable collection of essays.

Ronald E. Cordell, M.D., F.A.C.R.

Editor's Note: By accident we neglected to publish the name of Dr. Louis Palmer as the author of last issue's book review.

Tort reform

Dr. Ronald Cordell testifies at the public hearing on tort reform in the House chambers during the legislative session.

131st Annual Meeting Preliminary Program

Pre-Convention Meetings

Tuesday, August 25

6 p.m.	WVSMA Executive Committee Dinner/Business Meeting, Thomas H. Chang, MD, President, presiding

Wednesday, August 26

8:30 - Noon	Exhibit set-up
9 a.m.	Executive Committee/Council Meeting
11:30 p.m.	Executive/Council - Component Society President and Executive Secretaries Luncheon,
Noon - 4:30 p.m.	Registration, Exhibit Center Foyer
1 p.m.	Exhibit Visitation
12:30 - 1:30 p.m.	Delegate Registration

Convention Program

Wednesday, August 26

1:30 - 4:30 p.m. **FIRST SESSION HOUSE OF DELEGATES, Governor's Hall**

John D. Holloway, MD, Speaker of the House, presiding
Call to Order and Welcome
Introductions:
AMA President
Visiting State Presidents
WVSMAA President
WVSMA Medical Student Section President

2 p.m.	1997 WVSMA Award Presentations *Rural Health Physician of the Year* *WVSMA Presidential Citation* *Wyeth-Ayerst Physician Award for Community Service* AMA-ERF Awards
2:15 p.m.	**AMA's President Address** **Nancy W. Dickey, MD,** **1998-99 AMA President**
2:45 p.m.	Break
3:15 p.m.	Thomas L. Harris Address
4:30 p.m.	Business Meeting *Constitution and Bylaws Committee Report* *Nominating Committee Report and Speeches* *Introduction of Resolutions* Presidental Address, Thomas H. Chang, MD, 1997-98 WVSMA President
5 p.m.	Adjournment
6:30 - 7:30 p.m.	Presidential Reception

Thursday, August 27

8:30 - 3 p.m.	Registration, Exhibit Center Foyer
8:30 - 1 p.m.	Exhibit Visitation, Exhibit Center
8:30 - Noon	**FIRST GENERAL SESSION, Governor's Hall**
10 - 10:30 p.m.	Refreshment Break, *Courtesy of Chapman Printing Company*
Noon - 1:30 p.m.	**Lunch & Learn** *"Appropriate Scope of Practice"*
1:30 p.m.	Committee on Resolutions, Thomas H. Chang, MD, presiding, Open/Closed Session
2 p.m.	Golf, Tennis and Volleyball Tournaments
3 - 5 p.m.	WESPAC Meeting, Pierce Room
6 p.m.	WV Medical Institute Business Meeting
6:30 - 7:30 p.m.	Reception, *Hosted by Acordia of West Virginia and Medical Assurance of West Virginia*

Friday, August 28

7 a.m.	Breakfast Meetings (times and locations to be announced)
8:30 - 3 p.m.	Registration, Exhibit Center Foyer Exhibit Visitation, Exhibit Center
8:15 - Noon	WV Section on Dermatology Meeting
8:30 - Noon	**SECOND GENERAL SESSION, Governor's Hall**
Noon - 1:30 p.m.	**Lunch & Learn** *"Computers in Medicine"*
Noon	Specialty Meetings - Various chapters of West Virginia Specialty Socities will be scheduled for luncheon/business and scientific meetings. Times and locations will be noted at a later date.
12:30 p.m. - 2:30 p.m.	WVSMA Publication Committee Meeting Luncheon, Stephen D. Ward, presiding
2 -5 p.m.	Medical Assurance Loss Control Seminar
3 -5 p.m.	American Academy of Family Physicians
5:30 - 6:30 p.m.	Reception *Hosted by WVU/MU Schools of Medicine Alumni*
9 - Midnight	Entertainment, *Vito DiSalva and WE THREE*

Saturday, August 29

7:30 a.m.	Breakfast Meetings (times and locations to be announced)
8:30 - 9 a.m.	Delegate Registration and Voting
9:15 a.m.	**Second Session of the WVSMA House of Delegates, Chesapeake Hall** Speaker of the House, John D. Holloway, MD, Presiding Presentation of Colors Reaffirmation Necrology Report Recognition and Introductions Business Meeting Announcement of Election Results Constitution and Bylaws Committee Report, Harry S. Shannon, MD, Chairman WVSMA Resolutions Committee Report, David W. Avery, MD
10 a.m.	Flink Address, Robert J. Marshall, MD
11:30 p.m.	Recess for Lunch
Noon - 1:30 p.m.	WVSMA Component and Specialty Society Presidents, Past Presidents Visiting State Presidents and 50-year Medical Graduates Luncheon
1:30 p.m.	**Reconvene Second Session of the House of Delegates** Installation of Officers Oath of Office and Presidential Address, David Avery, M.D., Parkersburg, WV Adjournment
4 - 5 p.m.	Reception honoring newly installed officers of WVSMA and Alliance

The West Virginia State Medical Association

131st Annual Meeting

August 26-29, 1998

THE Greenbrier®
WHITE SULPHUR SPRINGS
WEST VIRGINIA 24986

- Scientific Sessions
- Specialty Meetings
- Two Lunch & Learn Programs
- Entertainment
- Tournaments
- Exhibits
- Receptions
- Enjoy the amenities and wonderful atmosphere of The Greenbrier!

Registration Form

Name _____

Address _____

City/State/Zip _____

Phone _____ **Fax** _____

Specialty _____

TO TAKE ADVANTAGE OF THE EARLY BIRD RATES, REGISTRATION FEES MUST BE RECEIVED BY AUGUST 1, 1998

Please detatch and mail with payment to:
WVSMA, P.O. Box 4106, Charleston, WV 25364.

Would you like to register over the phone? Just call us at (304) 925-0342. Please have your Visa or MasterCard ready.

Fax us your application! (304) 925-0345.

Request an e-mail registration form! Visit our website at www.wvsma.com. Complete our Guestbook and request a registration form!

Cancellation of registration should be in writing. If a cancellation is postmarked or phoned to the WVSMA before August 1, 1998, the paid registration fee will be refunded less a $50 administrative charge. For written or phoned cancellations after August 1, 1998, no refunds will be made.

Early Bird Registration Fees — Before August 1, 1998

❒ **WVSMA Member**	**$115**
❒ **Non-member**	**$165**

Registration Fees — After August 1, 1998

❒ **WVSMA Member**	**$125**
❒ **Non-member**	**$175**

Lunch & Learn —
Thursday, August 27, 1998 — *"Appropriate Scope of Practice"*
Friday, August 28, 1998 — *"Computers in Medicine"*

❒ **WVSMA Member**	**$50 (each session)**
❒ **All others**	**$35 (each session)**

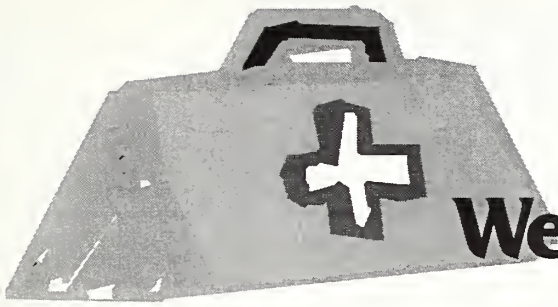
Total Due: _____

Payment by: ❒ Check ❒ MasterCard ❒ VISA

Card Number _____

Expiration Date _____

Signature _____



The Search Is On for Outstanding West Virginia Physicians

Why we honor our physicians

It is once again that time of year. Time to honor and recognize a fellow physician or outstanding individual who has made an invaluable contribution to medicine or health care in West Virginia. When nominating a fellow physician or a member or your community, please remember that this is an opportunity to recognize someone who has done excellent service to his or her community and has been an asset to the state of West Virginia. While honoring others we are all encouraged to act similarly.

The Awards

We are now accepting nominations for the Wyeth-Ayerst Physician Award for Community Service, the Rural Health Physician of the Year and the West Virginia Presidential Citation. The following awards will be presented at the 131st Annual Meeting at The Greenbrier, August 26-29.

The **Wyeth-Ayerst Physician Award for Community Service** recognizes a physician who has uniquely contributed to the community.

The **Rural Health Physician of the Year** recognizes a physician who offers exceptional medical care to patients in smaller, rural areas.

The **Presidential Citation** is awarded to a non-physician who has made a contribution to medicine or health care in West Virginia. Nominees could include reporters, volunteers, hospital staff, etc.

Act Now!

Take a moment to recognize our West Virginia physicians by nominating them for these prestigious awards. I will be happy to send you a nomination form and description sheet for the awards.

Please send me a nomination kit:

Name_____

Company

_____

Address

_____

City/State/Zip

Deadline for nomination is May 1, 1998.
Please send completed form to Christina R. Dixon, WVSMA Public Relations, P.O. Box 4106, Charleston, WV 25364. Questions, please call (304) 925-0342 or fax to (304) 925-0345.

CME & Special Events

Camcare Health Education & Research Institute

"Radial Artery Revisited"
April 14, 6 p.m., Kourosh Ghalili, M.D., Tamarack, Beckley

"Treatment of Depression in the Primary Care Practice"
(Teleconference) April 16, James Griffith, M.D.

"New Regulations from Medicare on Medical Necessity"
April 21, 5 p.m., David Anderson, M.D., Davis Memorial Hospital, Elkins

"Pediatric Advanced Life Support Provider Course"
April 23-24 & May 7-8, 8 a.m. - 4:15 p.m., Camcare Health Education and Research Training Center, Charleston

"Taking the Headache Out of Headaches"
April 29, 6 p.m., Harry Reahl, M.D., Tamarack, Beckley

"OB/GYN Update: A Pre-conference for the Family Practitioner"
April 30, 5 p.m. - 9:15 p.m., Charleston House - Holiday Inn, Charleston

"Urinary Stress Incontinence"
April 30 - May 1, 8 a.m. - 4:30 p.m., Women and Children's Hospital, Charleston

"Poison Treatment Controversies"
(Teleconference) May 7, Greg Rosencrance, M.D., and Elizabeth Scharman, Pharm.D.

"A.B.B.I: A New Breast Biopsy Technique"
May 8, noon, James Kessel, M.D., Logan General Hospital, Logan

"Treatment of Red Eye"
May 19, 6:15 p.m., James Caudill, M.D., Roane General Hospital, Spencer

Huntington Medical Community Foundation

"Radiation Oncology"
April 23, noon - 1 p.m., Philip Lepanto, M.D., or Sahneev Sharma, M.D., Pleasant Valley Hospital, Point Pleasant

"Pediatric Critical Care Conference"
April 25, 8 a.m. - 1 p.m., Williamson Emergency Services Building, Williamson

"Recent Advances in the Treatment of Hearing Loss"
April 27, 6 p.m. - 8 p.m., Thomas M. Jung, M.D., Logan General Hospital Staff Meeting, Kruger Building, Logan

"Common Dermatological Problems Seen"
April 27, 6 p.m. - 7:30 p.m., Amy Vaughan, M.D., Three Rivers Medical Center, Louisa, Ky.

"Cardiology"
April 28, 6 p.m. - 8 p.m., George Linsertmeyer III, M.D., Paul B. Hall Regional Medical Center, Paintsville, Ky.

"TBA"
6 p.m. - 7:30 p.m., Appalachian Regional Hospital, South Williamson, Ky.

"TBA"
noon - 1 p.m., Logan General Hospital, Logan

Marshall University School of Medicine

"Agitation & Aggression in the Elderly"
April 17, noon, John Kasckow, M.D., Riverpark Hospital, Huntington

"Management of Orthostatic Hypotension"
April 21, 8 a.m., Horatio Kaufman, M.D., Cabell Huntington Hospital, Huntington

"Impotence"
April 30, 1 p.m., Stanley Kandzari, M.D, Cabell Huntington Hospital, Huntington

"Snake Bites"
May 21, 1 p.m., Roger Smalligan, M.D., Cabell Huntington

Robert C. Byrd HSC - Morgantown

"Stephen Rector Lectureship"
Robert C. Byrd HSC, Morgantown

"Occupational Asthma: In and Out of the Work Place"
NIOSH, Morgantown

"AIDS in West Virginia '98"
Days Inn, Flatwoods

"Advances in Internal Medicine"
May 29 - 30, Robert C. Byrd HSC of WVU, Morgantown

Poetry Corner

March

It was the first smile of Spring
Following winter's grim face,
The clouds blown apart,
Displaying in grace
All God has to offer
In resplendent glory,
The beginning and end
Of a continuous story —
Season upon season, years upon years.

Then beyond reason, the sun disappears.

Just a fleeting smile,
A real bummer.
Oh how he longed for
The laughter of summer.

Robert L. Smith, M.D.

Too Gray, Too

Oh, how we dread to see the day
That's cloudless in the usual way.
Appalachian fog and rain
Mists the face and clouds the brain.

When off our hills we plummet down
To shop or visit in the town
And find 'nother day uniformed in gray,

What happens?
All good humor is blown away.

Lee Neilan, M.D.

Bureau for Public Health News

This page of material is submitted and paid for by the Bureau for Public Health.

Health departments coping with managed care, funding cuts

Local health departments have been experiencing firsthand the changing health care system and the impact of these changes on their ability to deliver public health services in their communities.

Over the past five years, state funds for local health departments have stayed constant; county dollars have been reduced. Less than one percent of all health care dollars in West Virginia are spent on public health services. The implementation of managed care has reduced the ability of health departments to generate revenue from the delivery of clinical services (well child exams, family planning, home health, etc.) to support basic public health services in counties. The new Federal Balanced Budget Act (passed in August 1997) severely limited the ability of 17 local health departments to provide home health services.

Local health departments are located in every county in the state. Over 1,200 West Virginians (1,000 full-time jobs) are employed in this industry, which amounts to $50 million. Local health departments are responsible for carrying out basic mandated public health services for every citizen of the state including:

- **Prevent, Manage and Control Communicable Diseases.**

  Such as vaccine preventable diseases, AIDS, sexually transmitted diseases, rabies, and outbreaks of Hepatitis B and tuberculosis by provision of disease surveillance and immunizations.

- **Environmental Health Services and Protection.**

  Such as food, milk, sewage, water and waste sanitation, as well as disaster response.

- **Monitor, Address and Prevent Community Health Risks.**

  Such as heart disease, infant mortality, physical activity, and poor health habits.

These issues have caused great disruption and changes to local health departments. Several local health departments are in the process of reducing services, laying off staff or in the position of having to consider closure. The governor's budget contains $4.3 million in new funds to address this issue.

Local health departments and the State Bureau for Public Health have been working together over the past year to address these problems and re-engineer public health services in the state. However, additional funds are needed to address the immediate "crisis," provide funds for basic public health services, and transform the public health system to meet the demand of the 21st Century.

Discounts for telecommunications to be available soon

A special presentation entitled *"Rural Health Care Provider Telecommunication Discounts - How Do I Get the Money?"* was broadcast over Mountaineer Doctor Television on December 12 to help inform rural health care providers about how to access discounts that will be available during 1998.

Presenters included Elliot Maxwell, Federal Communications Commission; Stan Cavendish, Bell Atlantic - West Virginia; Gene Laffitte, West Virginia Public Service Commission; Rich Rhyner, National Exchange Carriers Association; and Isiah C. Lineberry, Rural Health Care Corporation board member and former director of the West Virginia Office of Rural Health Policy. Rural hospitals, health departments, behavioral health centers and others participated in the live-interactive broadcasts at multiple sites. The application for the discounts should be available in the near future. The presentation was coordinated by the Office of Rural Health Policy, West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Community and Rural Health Services.

For additional information, contact Susan Griffith, Assistant Director, OCRHS, 1411 Virginia Street East, Charleston, WV 25301, at (304) 558-3210, or by e-mail at: Sgriffith@bph.wvdhhr.org

National Safe Kids Week set for May 2-9

The West Virginia Safe Kids Coalition is a member of the National Safe Kids Campaign and is housed within the West Virginia Bureau for Public Health at the WV Office of Emergency Medical Services.

To draw attention to its goal of reducing the number of unintentional injuries for West Virginia's children, the Coalition's 20 chapters throughout the state will be celebrating National Safe Kids Week May 2-9. The theme for 1998 is *"At Home, At Play, and On the Way."*

The National Safe Kids Campaign is a program of the Children's National Medical Center of Washington, D.C. This program was founded in 1987 to prevent unintentional injuries which are the number one killer of children ages 14 and under.

The coordinators for the Coalition are Penny Byrnside (304) 558-3956 and Patty Hawkins (304) 366-8764.

SJMH acquires advanced endoscopic ultrasound

Stonewall Jackson Memorial Hospital has recently acquired a B&K Medical Endoscopic Multiplane Ultrasound Type 8551. This modern equipment can acquire and interpret highly accurate cross-section ultrasonic images obtained from the prostate gland, rectum and anus. The literature describes this technology as being an effective aid for detecting and diagnosing:

- focal lesions in the prostate (especially cancer)
- the presence and extent of anal sphincter trauma (e.g. obstetric post-partum)
- the presence and extent of lesions and metastases in the rectum

SJMH staff physicians Roger Pons, MD, FACS, FASCR (board certified colon rectal surgeon and Arnold Gruspe, MD (urologist) are responsible for acquiring and interpreting images with this technology.

Interested physicians may contact Dr. Gruspe or Dr. Pons for information and/or consultation.

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New Guidelines Call For Increased Calcium Recommendations

- Two out of three Americans *do not* get enough calcium in their diets.
- The new recommendations are based on intakes consistent with maximal calcium retention to increase bone mass and reduce the risk for osteoporosis.
- Calcium intake recommendations are higher than the previous RDA's for most age groups.
- The American Medical Association and The American Dietetic Association recommend calcium-rich foods like milk and milk products as the preferred source of calcium.

Call 1-800-778-MILK to request complimentary nutrition education resources.

New Calcium Recommended Intakes*

Age	Daily Recommendation	
1-3 years	500 mg	2 servings
4-8 years	800 mg	3 servings
9-18 years	1300 mg	4 servings
19-50 years	1000 mg	3 servings
51+ years	1200 mg	4 servings

What Is A Calcium Serving?

1 cup whole, reduced-fat, fat-free or flavored milk
1 cup yogurt
1 1/2 ounces natural cheese
1 cup pudding made with milk

**Source: National Academy of Sciences, August 1997*

Dairy Council Mid East, an affiliate of National Dairy Council

Robert C. Byrd Health Sciences Center of West Virginia University News

Dr. Doyle named interim head of occupational health

Doyle

Dr. Edward J. Doyle has been named interim director of the Institute for Occupational and Environmental Health at WVU.

Dr. Doyle, an associate professor of family medicine in the WVU School of Medicine, has been the Institute's clinical director since 1995. In this role, he has supervised the health care provided to people who come to the WVU for treatment of work-related injuries or illnesses, or exposure to chemicals. He is also a consultant and medical evaluator for WV Workers' Compensation.

The Institute provides graduate training to physicians interested in occupational health, and services about workplace health to workers, employers, and government agencies.

Dr. Kaufman has two books published

Kaufman

Dr. Howard Kaufman, chair of neurosurgery at WVU, is co-editor of a two-volume book, *The Physician's Perspective of Medical Law,* which was recently released by AANS Publications. He authored seven chapters of the book.

Dr. Kaufman is also the author of another new book from AANS entitled *Cerebrospinal Fluid Collections.*

Eye Center studies cataract drug

Macsai

WVU physicians are testing a new medicine that may prevent clouding of vision after cataract surgery.

The University Eye Center is one of 60 sites nationwide participating in tests of MDX-RA, a genetically-engineered drug given at the end of cataract surgery. Dr. Marian Macsai, associate professor of ophthalmology, says that up to half of cataract patients who are fitted with artificial lenses later develop an overgrowth of epithelial cells that clouds the vision. MDX-RA is a therapeutic immunotoxin that researchers hope will target and kill the epithelial cells responsible for the clouding.

For further information about the trial, contact the Clinical Research Trials Unit at (304) 293-7472.

Miss America to speak at STD/AIDS seminar

Miss America 1998 Kate Shindle will be a dinner speaker at the West Virginia STD/AIDS Conference May 7-9 in Flatwoods.

The conference annually brings together health, community and patient groups working to combat sexually transmitted diseases. This year's theme, *"Education, Prevention, and Treatment in a Time of Great Change,"* reflects the volume of new clinical information available to healthcare workers and educators.

Shindle travels the country to talk with school groups and others about the importance of preventing AIDS.

The conference is organized into six tracks, including clinical, community/prevention, education, pharmacy, nursing, and social services tracks. In addition, there are workshops with an emphasis on dentistry and pastoral care, and for those who are affected by, or infected with, STDs or HIV. The conference is again being jointly sponsored by the West Virginia Department of Health and Human Resources and WVU.

For information or registration, contact the WVU Office of CME at (304) 293-3937 or visit the Physicians Page on the Internet at: **www.wvmd.wvu.edu.**

Biosafety officer hired

To make sure all researchers know and follow established safety procedures when working with materials that pose biological hazards, Andrew Cockburn, Ph.D., has joined WVU's faculty as the new institutional biosafety officer.

Dr. Cockburn has more than a decade of experience in biosafety issues. He was a research geneticist for the USDA in Gainesville, Fla., from 1986-97, and was a member of the Biotechnology Research Guidelines Committee for USDA-ARS.

County services listed

The Robert C. Byrd Health Sciences Center compiles an annual report of services provided to each county in West Virginia. The entire report is available electronically on the West Virginia Health Page at: **www.wvhealth.wvu.edu**.

Printed copies for any county are available by calling the MARS line (1-800-WVA-MARS.)

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Marshall University School of Medicine News

Most MU grads choose to remain in state, practice primary care

Fourth-year med students Janelle A. Thomas and J. Patrick Fouts III exchange congratulations at the Match Day reception while Fouts' wife, Susan, looks on.

During Match Day at Marshall University, it was announced that two-thirds of 1998 Marshall's medical graduates entering residencies this summer will continue their training in the primary care specialties. Sixty percent will remain in West Virginia for their residencies.

Based on results of the National Resident Matching Program, 25 of the 42 grads entering residencies will do their advanced training in Huntington and Charleston. More than 21 percent (9 graduates) will enter FP residencies. In addition, eight graduates will enter general internal medicine, three grads will enter pediatrics, four will enter medicine/pediatrics and four will enter obstetrics and gynecology.

NRMP figures indicate 84 percent of MU graduates who matched received their first-choice program, which is about 50 percent higher than the national average of 54.9 percent. Marshall students were accepted into programs at Yale University, George Washington University and the Mayo Graduate School.

Physician groups merge with MU

Two prominent Huntington physician groups, Pathology Services Group Inc. and Pediatrics Incorporated have merged with their respective departments at Marshall, according to Dean Charles McKown.

"These are simply outstanding groups of physicians who have long provided important service to the school. Deepening their involvement in this way can only enhance our educational program," Dr. McKown said.

Dr. David Porter is chairman of the Department of Pathology, with Dr. Ernest Walker serving as vice chairman. In addition to Dr. Porter, new members of the full-time faculty include Dr. Linda Brown, Dr. John Sheils and Dr. William E. Triest.

Dr. Joseph Werthammer is chairman of the Department of Pediatrics, which now has two centers dedicated to pediatric specialty services and five general pediatrics offices in Huntington, Hurricane, and Ironton, Ohio.

WWW program named semifinalist

The School of Medicine's ground-breaking Interactive Patient program on the World Wide Web has again received world-wide recognition: it was named a semifinalist in the Global Information Infrastructure Awards, described by USA Today as "a cross between the Oscars and the Baldrige Awards of the Internet."

Marshall's program, a simulated patient on whom doctors can test their diagnostic skills, was created in 1995 by Kent Hayes, director of clinical and administrative computing, and Dr. Christoph Lehmann, who is now at Johns Hopkins University. It was a semifinalist in both the education category and the health category for the Global Information Infrastructure Awards.

The Interactive Patient is a one-of-a-kind WWW teaching tool that allows health professionals and other users to simulate a patient encounter. Users can interview the "cyberpatient," perform a physical exam, listen to heart and other sounds, order lab tests and view X-rays. The program is approved to provide CME credit.

"The Interactive Patient is unique among patient simulations both because it is Internet-based and because of its natural language processing capability," said Michael McCarthy, assistant dean for information technology and medical informatics at MU. "Users can access this resource from anywhere in the world. Plus, they can ask questions of the patient in full sentences, which helps to recreate a realistic patient encounter. Mr. Hayes and Dr. Lehmann should be proud of their pioneering work."

The program has won dozens of awards, and last year was a semifinalist in the National Information Infrastructure Awards program.

The Interactive Patient can be found at:
http://medicus.marshall.edu/medicus.htm

EVEN WITH MS, GEORGE GANT HAS DESIGNS ON THE FUTURE

George is working his way up the corporate ladder a little differently. He's using a "scooter." Because George has multiple sclerosis, a chronic disease of the central nervous system.

A chemist, George is not content to sit back and mount up patents and industry awards. He has earned honors from almost a dozen state and local organizations for his contributions to the community.

Now, George develops quality improvement programs for his Michigan-based employer and helps to integrate other physically challenged workers into the corporate mainstream.

While his physical future is uncertain, George is unyielding in his belief that someday a cure for MS will be found. The National Multiple Sclerosis Society is bringing that day closer by funding vital research in genetics, virology and immunology. To find out more about the Society and its services, call 1-800-624-8236. Help a quarter of a million Americans with MS help themselves.

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West Virginia School of Osteopathic Medicine News

Dr. Stookey receives national, state honors

Stookey

James Stookey, D.O., vice president for academic affairs and dean of WVSOM, has received three honors from the osteopathic medical community.

Dr. Stookey was elected by his peers as a "Distinguished Practitioner" in the National Academy of Practice (NAP) in Osteopathic Medicine. The NAP is composed of the academies of Allopathic Medicine, Dentistry, Nursing, Optometry, Osteopathic Medicine, Podiatric Medicine, Psychology, Social Work, and Veterinary Medicine. Only 100 active "Distinguished Practitioners" may be elected to each academy.

Dr. Stookey has also recently been accorded life membership in the American Osteopathic Association by the AOA Board of Trustees, as well as a lifetime membership in the West Virginia Society of Osteopathic Medicine, Inc.

WVSOM bestowed academic health center status

The WVSOM has attained the status of "Academic Health Center" as set forth in guidelines developed by the American Association of Colleges of Osteopathic Medicine (AACOM), announced Olen E. Jones Jr., Ph.D., president of WVSOM.

"Being designated an academic health center shows that WVSOM is meeting the national standard set by AACOM," said Dr. Jones. "It lets us know we are moving in the right direction."

AACOM defines an academic health center as a college of osteopathic medicine which has a cooperative agreement with at least one other health professions school. Howard Hunt, D.O., associate dean for clinical education explains that WVSOM's ties with WVU qualifies it as an academic health center.

"WVSOM has an affiliation agreement with WVU Hospitals, Inc.," said Dr. Hunt. "We have an osteopathic internship established with them, and we will also eventually have training opportunities in place for WVSOM medical students in their third and fourth years of clinical rotations," he said.

Dr. Nemitz to direct graduate retention

Nemitz

Jim Nemitz, Ph.D., associate professor of anatomy, has been named to a new post at WVOM — director of physician underserved and rural retention.

In this position, Dr. Nemitz will work with all departments at WVSOM — from student recruitment through post-graduate education — to encourage WVSOM graduates to remain in the state and to practice in areas that have a shortage of physicians.

Dr. Nemitz joined the WVSOM faculty as an adjunct professor of anatomy in 1984. Before coming to WVSOM, he taught at the Medical College of Virginia in Richmond, where he earned his Ph.D., and at the Yale University School of Medicine, where he did a postdoctoral fellowship. In addition to his new responsibilities, Dr. Nemitz will continue to teach anatomy as an associate professor.

Dr. Hassan to assume new technology post

Hassan

WVSOM President Olen Jones has named Arnold Hassan, Ph.D., director of professional development and professor of physiology, to the newly created post of chief technology officer.

In this new position, Dr. Hassan will be responsible for planning, coordinating, and managing all activities related to technology at the school, including support of the business office and other administrative offices, undergraduate and postgraduate educational programs, and support of the overall mission and goals of WVSOM and the osteopathic profession.

Dr. Hassan joined the WVSOM faculty as an associate professor of physiology in 1983. Prior to coming to WVSOM, Dr. Hassan was an assistant professor of physiology at the University of Texas Health Science Center in San Antonio, and research assistant professor of neurology at the Uniformed Services University of the Health Sciences in Bethesda, Md.

Six students win health science scholarships

Six students from WVSOM were recently named as $10,000 West Virginia Health Sciences Scholarship winners.

The students awarded scholarships were: Connie Anderson of Lewisburg; Sarita Bennett of Marlington; Marie Fearon-Jewell of Morgantown; Frank Swisher of Jane Lew; June Willard of Oceana; and Abigail Winters of Lewisburg.

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Susan D. Maynard, M.S., CCC-A
Janet D. Lauerman, M.A., CCC-A
Brenda D. George, M.S., CCC-A
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WVSMAA sponsors Legislative Workshop

At the Legislative Workshop sponsored by WVSMAA during this year's WVSMA Mid-Winter Clinical Conference, WVSMA President Thomas Chang joined Kathy Fortunato, WVSMAA president (*third from left*), and Nidia Henderson, the WVSMA's director of government relations and executive secretary of the Alliance (*fifth from left*), for a group portrait with Alliance members Myla Amsbary, Joyce Rabinal, Bonnie Fidler, Alba LaCarbonara, Jacqui Yee, Judy Bofill, Sarah Wade, Carole Scaring and Rose Romero.

Speaker of the House of Delegates Robert Kiss gestures as he addresses the physicians and Alliance members attending the Legislative Workshop about the status of various bills in the Legislature.

Dr. Walker's talk highlights Annual Meeting

Dr. Robert Walker, professor and chairman of the Department of Family and Community Health at the Marshall University School of Medicine, visits with some of the medical students before his presentation on *"Who Controls Medicine? Is Autonomy Impossible?"* during the WVSMA-MSS Annual Meeting at the Charleston House - Holiday Inn.

Amber Kuhl-Meade, president of the MU Medical Student Section, discusses legislative issues with Dr. Thomas Chang, president of the WVSMA, and George Rider, executive director of the WVSMA.

Jason Harrah, WVSMA-MSS president for 1997, addresses the medical students at the start of the Annual Meeting. Seated by him are Stephen Greer, vice president of the WVSMA-MSS who is now serving as president for 1998, and Claire Sanger, secretary/treasurer of the WVSMA-MSS for the past year.

New Members

We are pleased to welcome the following new members to the WVSMA as of 3/13/98:

Physicians

David Morris, MD
Martinsburg, WV

David C. Beckner, MD
Parkersburg, WV

Manuel C. Barit, MD
Mullens, WV

Laurie J. Winchester, MD
Parkersburg, WV

Kellie K. Gooding, MD
White Sulphur Springs, WV

John J. Battaglino, Jr., MD
Wheeling, WV

Brian T. Mann, MD
Berkeley Springs, WV

Mariamma Abraham, MD
Beckley, WV

Joshy Abraham, MD
Beckley, WV

Suratkal V. Shenoy, MD
Keyser, WV

Jack M. Levine, DO
Pt. Pleasant, WV

Victor V. Villarreal, MD
Clarksburg, WV

Phillip C. Van Dongen, MD
Martinsburg, WV

Trumer Wagner, MD
Martinsburg, WV

Kathleen R. Rosen, MD
Morgantown, WV

Hussein El-Khatib, MD
Charleston, WV

Imad S. Basha, MD
Clarksburg, WV

Anil Agarwal, MD
Bluefield, WV

Mariza A. Lirio, MD
Crab Orchard, WV

Apolonio E. Lirio, Jr., MD
Crab Orchard, WV

Charles McMullin, Jr., MD
Huntington, WV

Hedy J.M. Windsor, MD
Parkersburg, WV

Lee P. Theaker, MD
Wheeling, WV

Mark S. Chandler, MD
Beckley, WV

Joe Prud'Homme, MD
Beckley, WV

Lawrence Marr, MD
Wheeling, WV

Frank Dombkoski, DO
Clarksburg, WV

Thomas N. Walker, MD
Clarksburg, WV

Joseph Stadelnikas, MD
Clarksburg, WV

Narendrakumar M. Patel, MD
Beckley, WV

Saravut Fung, MD
Clarksburg, WV

Henry Breland, MD
Charleston, WV

Dante A. Marra, MD
Wheeling, WV

Terry W. Capel, MD
Parkersburg, WV

Scott A. Naegele, MD
Charleston, WV

Arun Seth, MD
Bluefield, WV

Ralph E. Wood, DO
Moundsville, WV

Mark K. Stephens, MD
Charleston, WV

Michael Spindel, MD
Huntington, WV

Gina M. Fedel, MD
Weirton, WV

Lubin C. Alimario, MD
Weirton, WV

George M. Roig, MD
Weirton, WV

George Pickett, MD
Charleston, WV

Gary J. Tucker, MD
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Radha K. Krishnan, MD
Bluefield, WV

Robert J. Blok, DO
Beckley, WV

Scott W. Beattie, MD
Wheeling, WV

Joseph J. Talavera, MD
Parkersburg, WV

Ronald Brownfield, DO
Huntington, WV

Sanjay Gupta, MD
Weirton, WV

Kevin P. Kinkead, MD
Charleston, WV

Manu N. Patel, MD
Beckley, WV

Catherine E. Grant, MD
Weston, WV

Bennett D. Orvik, MD
Weston, WV

Norma J. Mullins, MD
Beckley, WV

Charles E. Porterfield, MD
Beckley, WV

Clyde P. Mitchell, MD
Buckhannon, WV

Anandhi Murthy, MD
New Martinsville, WV

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Parkersburg, WV

Juan Llado-Martinez, MD
Grafton, WV

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Todd Chertow
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Huntington, WV

William C. Wallace
Huntington, WV

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Morgantown, WV

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WESPAC News

We would like to thank the following physicians and alliance members for their 1998 contributions to WESPAC: (This list includes all contributors to date as of 3/20/98.)

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- ❑ Contacted your legislators about cosponsoring/supporting gag clause, patient protection, or other piece of medicine related legislation?
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- ❑ Attended a town hall meeting?
- ❑ Helped to set up a health care issues forum?
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- ❑ Made a commitment to assist on a campaign?
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For more information on political involvement, contact your state medical society or the AMA Washington Office at 202.789.7466.

Obituaries

Norman B. Bsharah, M.D.

Dr. Norman B. Bsharah, 77, former chief of medicine at St. Francis Hospital in Charleston, died February 6 in General Division, CAMC, after a long illness.

Dr. Bsharah was a graduate of Charleston High School and Morris Harvey College. He studied pre-med at West Virginia University and received his medical degree from Case Western Reserve in Cleveland in 1951.

During World War II, Dr. Bsharah was in the Army Air Corps and flew 50 missions as a navigator over North Africa. In addition, he was a captain in the Air Force Medical Corps during the Korean War.

Dr. Bsharah spent 45 years as a family practitioner in Charleston and Poca. He had been a member of the WVSMA since 1954 and was a member of the Kanawha Medical Society and the AMA.

A past president of the parish council at St. George Orthodox Church, Dr. Bsharah was also a member of the Order of St. Ignatius as Knight Commander and a former member of the board of trustees of Antiochian Orthodox Archdiocese of North America. In addition, he was a member of the Masonic Lodge, Scottish Rite-Beni-Kedem Shrine and the Phoenicians Club.

Survivors include his wife, Rosemary; daughter, Catherine Dempsey of Charleston; son, Norman Andrew Bsharah of Charleston; sisters, Violet Clair of Livonia, Mich.; Georgia Howard of Charleston; brothers, Theodore Bsharah of Sylvester, Mike Bsharah of Redford Mich., Alfred Bsharah of Livonia; and one grandchild.

The family suggests donations to St. George Eastern Orthodox Church, Charleston.

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6. Tables.
7. Legends for illustrations.

All persons designated as authors should qualify for authorship. Each author should have participated enough in the work to take public responsibility for the concept.

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8:00 a.m. to 4:15 p.m.

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April 30, 1998
Charleston House Holiday Inn
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5:00 p.m. to 9:15 p.m.

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8:00 a.m. to 4:30 p.m.

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June 4, 1998
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Fayette County Medical Society
Oak Hill, WV
April 1, 1998, 6:00 p.m.
Steven Jubelirer, MD

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Jackson General Hospital
McCoy's Best Western
Ripley, WV
April 8, 1998, 6:00 p.m.
Kenneth Starling, MD

Radial Artery Revisited
Tamarack
Beckley, WV
April 14, 1998, 6:00 p.m.
Kourosh Ghalili, MD

New Regulations from Medicare on Medical Necessity
Davis Memorial Hospital
Elkins, WV
April 21, 1998, 5:00 p.m.
David Anderson, MD

Taking the Headache out of Headaches
Tamarack
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April 29, 1998, 6:00 p.m.
Harry Reahl, MD

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Logan General Hospital
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James W. Kessel, MD

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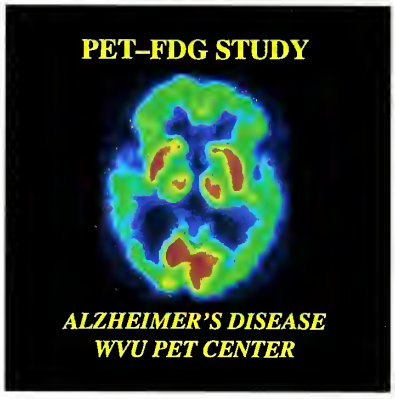

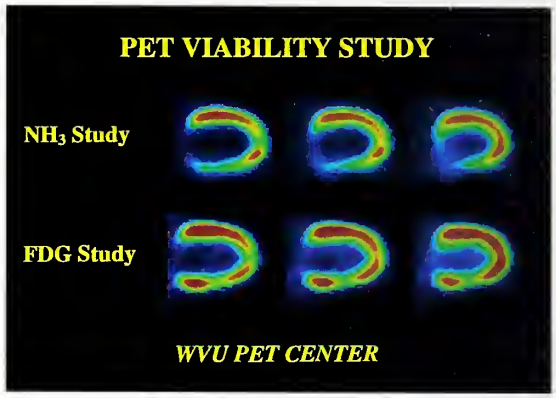

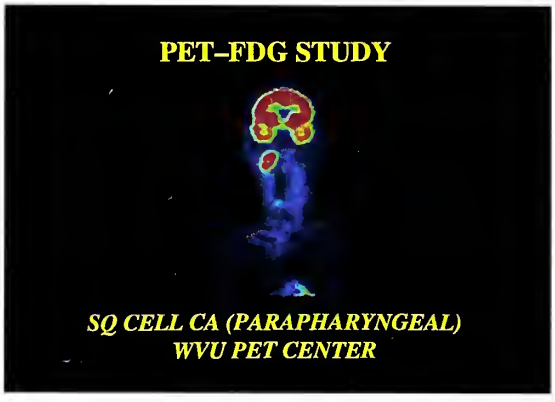

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West Virginia Medical JOURNAL

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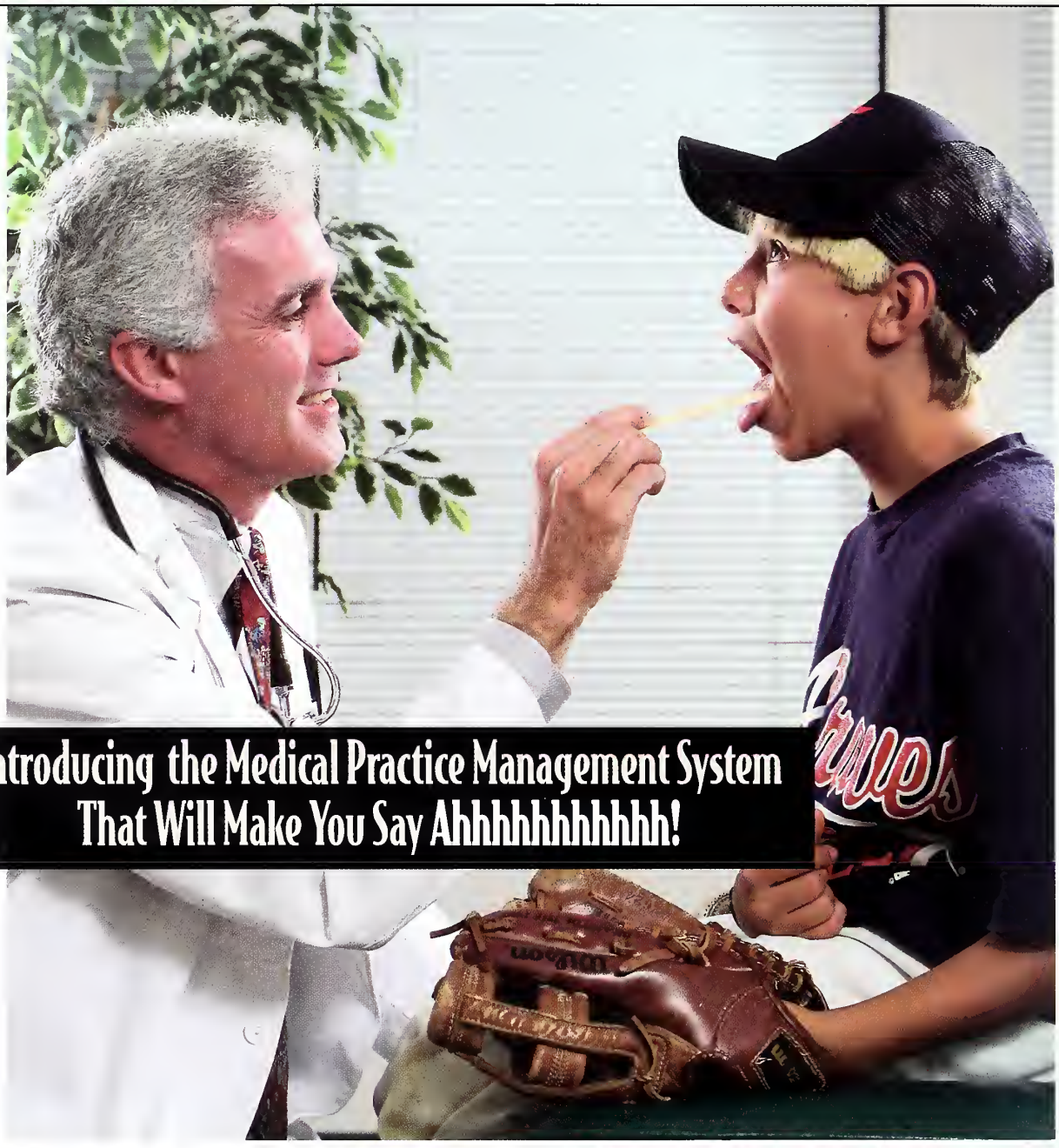

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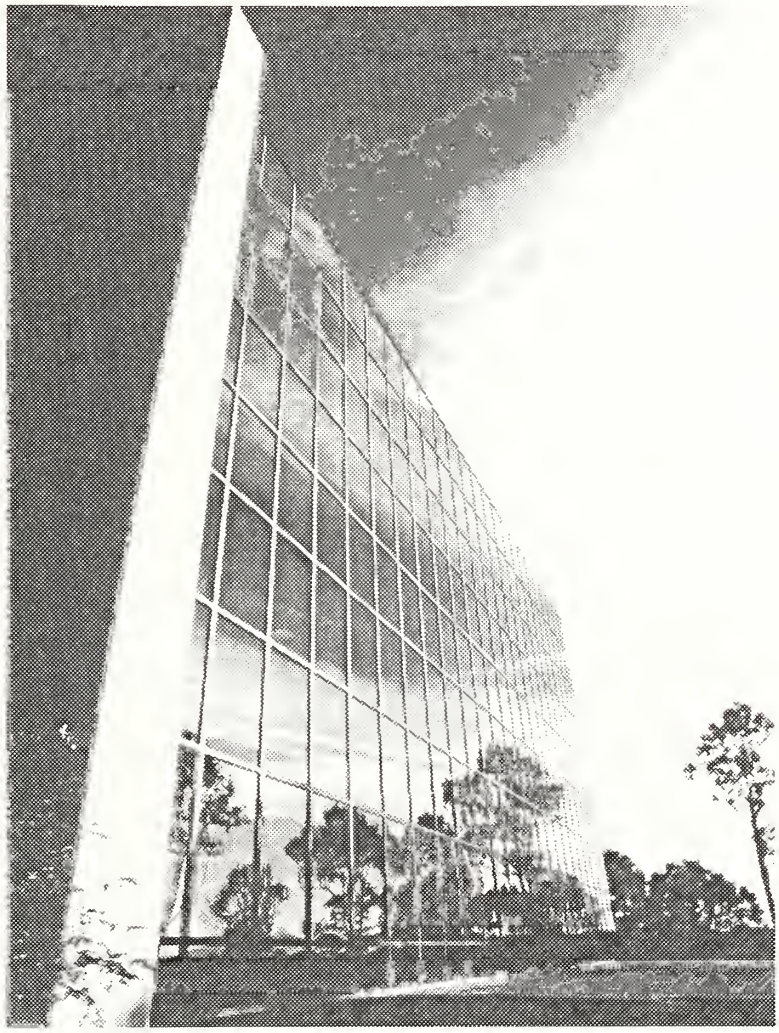

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WVSMA members enjoy a multitude of hobbies including underwater photography. This photo of a French angelfish in the Cayman Islands was taken by Dr. Ron Hill of the West Virginia University School of Medicine in Morgantown.

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If you have questions or need more information, phone Nancy L. Hill, managing editor at (304) 925-0342.

President's Page

A plan of action

Imagine what would happen to the quality of our health care if nurse practitioners replaced physicians as gatekeepers for HMO patients care.

Consider the impact on physician-patient relationships if all state-funded recipients were required to join HMOs.

And what would result if the Certificate of Need process and hospital rate setting were eliminated?

Unfortunately, these are just some of the threats to our state's health care system, and they are very real. As members of the West Virginia State Medical Association, it is in our best interest - - indeed, it is our responsibility - - to do everything we can to defend the quality of our profession and the patients in our care.

With that in mind, the WVSMA is gearing up for the 1999 legislative session. At the meetings of the Executive Committee and Council in May, we made a commitment to increase our communication and lobbying activities.

I'm pleased to inform you that we will be initiating a quarterly newsletter, *"House Calls,"* to be sent to all legislators beginning in July. This will serve as yet another forum for our members to raise policy concerns.

In addition, we will be adding a contract lobbyist to our team, who can help us meet our goals of repealing the physicians' provider tax and monitoring and working closely with the Governor's Tax Fairness Commission. Our lobbyist will also help us continue our efforts to re-enact the tort reform bill next year.

However, our duties do not end here. We are counting on each and every member to become a viable and valued part of the process. It is up to us to help lawmakers understand the complex health care issues that lay before them. Given the short amount of time the Legislature is in session and the number of bills that must be considered, we must use our expertise to help guide them in their decision-making.

We can do this most effectively by:

Advising policymakers with objective, accurate information;

Acting as a resource of medical information; and

Involving ourselves not only in the decision-making process, but also in the implementation of new laws and regulations that require our expertise.

We assert that our input is needed not from a position of arrogance, but rather from the years of personal sacrifice, education, residency and practice that permit us to use the title of M.D. or D.O. Government must learn to look to us as a part of the solution not a part of the problem when it comes to resolving issues involving medical care.

Along this line of thinking, it is time that society address a variety of troubling ethical questions.

Who will get the newest cancer drugs first? Children? Those who are most ill? Or those who can pay?

What treatments and medications should be covered by Medicare? Medicaid?

What is the long-term future of a Medicaid program that is not recognized as a societal obligation?

Surely, these are all issues on which we hold strong opinions. Lawmakers should know what our opinions are; after all, these issues are part of our daily lives. We know best what makes the most sense to keep the quality of health care at the highest levels.

As your president, I implore you to begin dialogue now with your legislators and continue talking with them throughout the next legislative session. Although it may seem insignificant to you, that one letter or phone call from you could be the deciding factor for your legislator on a key issue.

The commitment to get involved will pay off tenfold, not just for you and for our profession, but for patients around the state as well.

Thomas H. Chang, M.D.

Medical unions

It was inevitable with the increasing power and influence of managed care organizations that serious talk of organizing medical care unions for doctors would arise. Such talk is now current in many state medical organizations making up the federation of organized medicine.

Unionization has always been a delicate subject for organized medicine. The AMA has for generations been accused of being a "medical union" by its detractors, but unlike another supposedly professional group, the National Education Association, the AMA has actively discouraged any activity which might even resemble organized job actions which could be considered threats to withhold services for any reason. The AMA has been more than actively encouraged in this position by a terroristic Justice Department seeking some or any basis for bringing an antitrust suit against AMA for even a hint of encouraging organized group activity.

Long before such ambiguous government encouragement, however, AMA was opposed to the whole idea of a union philosophy or attitude for its members. Physicians are members of a "profession" and as such are guided by the ethical standards of that profession as well as the dictates of their learning and skills. As members of the Medical profession, physicians are ethically bound solely by the health and best interests of the patients under their care. Unions are primarily self-serving organizations.

How then is it possible to justify the formation of unions composed of physicians?

The first problem, the one with the Justice Department, has been clarified somewhat; it is now recognized and accepted that when physicians become employed persons, when their wages, hours and conditions of employment are under the control of and set by others, physicians have as much right as any other worker to engage in group negotiations over these matters. A number of hospitals throughout this state have been busy buying up physician practices thus setting up proper circumstances for the erection of legal medical unions. When, however, it can be established that a physician is actually functioning as an "independent provider," he has no rights under any labor law and cannot engage in group negotiations.

These technicalities aside, other important matters need to be established and quite probably to be litigated. We have been pointing out for years that under HMOs and other forms of managed care, the real losers have been *patients*, not doctors. Patients are being fraudulently enticed into contracts for care for which there is neither the intention nor the possibility of fulfillment; they are being denied care they have every right to expect; they are being made to suffer unnecessarily and have had their physicians intimidated, or worse, corrupted, all in the name of rosey-looking corporate bottom lines. It is our profession's obligation to correct these injustices being suffered by our patients. Our obligations to our patients have been corrupted and have been widely abandoned.

We need to have no self-serving interests in pursuing the goal of protecting the health and best interests of our patients. Doctors need no one or no outside entity to protect their incomes. We are unlikely to have worries about registering for food stamps under any circumstances.

Our ethical obligations toward our patients, however, require us to make the welfare of those patients our primary concern. If it takes union-like activity against managed care organizations to accomplish these obligations, so be it.

Stephen D. Ward, M.D.
Editor

Intercepted Communications

Editor's Note: *This memorandum was sent to us for publication by its author H. John Rogers, an attorney in New Martinsville, who is also an ordained minister. He welcomes comments from our readers.*

To: Robert V. Berthold, Chair, Law & Medicine Committee, West Virginia State Bar; and all committee members

From: H. John Rogers, Subcommittee Chair

Re: Legal/Medical Issues Relating to Pain Management

"In my conversations with physicians around West Virginia, I have learned that your observation is correct; physicians under-medicate patients because of concerns of disciplinary action by the West Virginia Board of Medicine. Alvin H. Moss, M.D., Director, Center for Health Ethics and Law, West Virginia University, Morgantown. Letter, 17 April 1998, to H. John Rogers.

This letter was in response to a letter that I sent to Robert M. D'Alessandri, M.D., Dean of the WVU School of Medicine. It was referred to Dr. Moss for reply, and a copy of Dr. Moss's letter to me was sent to Dr. D'Alessandri. *(I sent identical letters to the deans of the other two medical schools in the state, but, as of the date of this memorandum, I have not received a reply.)*

What might be loosely denominated as the modern era of pain management in WV begins with a 24 February 1997 letter from A. Paul Brooks, M.D., president of the WV Board of Medicine to all physicians in the state.

In this letter, Dr. Brooks states: "All physicians who hold a West Virginia license granted by this Board, by Board rule are subject to the AMA Code of Medical Ethics . . .

The en toto incorporation of "national" standards by a local administrative body raises some interesting legal issues. For example, the standard of care in medical malpractice cases is a local one, so why should pain management issues be treated differently? Also, WV lawyers are not bound by ethical standards promulgated by the ABA.

Few physicians, confronted with the gray areas of pain management, would be so rash as to risk their practices on a states' rights argument. Compounding this problem is the fact that the AMA, like most national special interest groups, must appeal to the lowest common denominator within its membership. With the possible exception of abortion rights, few have ever accused the AMA of being on the cutting edge of many social issues.

In his letter to state physicians, Dr. Brooks refers to three AMA Code of Medical Ethics opinions. It is interesting to note that none of these opinions - - the purported guidelines to WV physicians - - deal directly with the issue of pain management. They are captioned no. 2.20, "Withholding or withdrawing life-sustaining medical treatment"; no. 2.21, "Euthanasia"; and no. 2.211, "Physician-assisted suicide."

The first opinion, near the end, contains these words: "Physicians have an obligation to relieve pain and suffering and to promote the dignity and autonomy of dying patients in their care. This includes providing effective palliative treatment even though it may foreseeably hasten death."

Thus, under this opinion, with a dying patient, a physician may prescribe a medication which palliates but does not treat the patient, even though this may hasten death. *(This is the sort of situation addressed by an old preacher who told me, "Morphine has done away with deathbed repentances.")*

The euthanasia opinion and the physician-assisted suicide opinions both conclude with the same sentence: "Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communications."

There is no attempt to define "adequate pain control" in these two opinions, so this crucial issue would, presumably, be left to the vagaries of an ex post facto judgmental procedure. The consequence, as is noted above, is that most physicians would choose to err on the side of undermedication in these areas, rather than to risk formal charges.

In the final paragraph of his 1997 letter, Dr. Brooks states that a Committee of the Board is studying:

a) The issues of terminal cancer management;

b) Acute pain management; and

c) Chronic, long-term, non-terminal pain management.

"This committee will be working on developing helpful guidelines in these areas and informing you [i.e., WV physicians] of them in the future," Dr. Brooks concluded in his letter.

An inquiry to the WV Board of Medicine produced its *"Position statement on the use of opioids for the treatment of chronic non-malignant pain."* This statement deals with "the management of acute pain and cancer pain," and says there is a dual purpose: a) so that "patients will receive quality pain management", and b) so that physicians will not fear "legal consequences, including disciplinary action by the Board . . ."

After pointing out that opioids are appropriate treatment for non-malignant pain only for "selected patients", the statement lists 11 items which should be included in the management plan. For example item no. 2 states that "special attention" should be paid to "substance abuse" and "effective use of analgesics" without specifically stating how and in what fashion these factors are weighted. Is a heavy drinker to be excluded? What about a recreational drug user?

Similarly, according to item no. 3, a "psychiatric disorder" or "home environment" which "might place the patient at high risk for non-compliance" would preclude the prescribing of opioids.

Although arguably relevant, these items seem to be only tangentially related to someone with, say, chronic back pain. More relevantly, the absence of drug and psychosocial histories in the patient's file could certainly be taken as evidence of violation of the Board's position statement.

Upon receipt of the opioid statement, I again wrote the Board to see if there were any other pain management guidelines issued by the Board subsequent to Dr. Brook's 1997 letter. *(The opioid statement was actually issued on* 14 *July 1997.)* The answer was "no" and I was referred to a podiatrist member of the Board for any questions dealing with "non-malignant pain." I wrote to the podiatrist but as of this date, I have not received an answer.

Dr. Moss - - a line from whose letter I quoted at the beginning of this memorandum - - advised me that HB 4058, "Management of intractable pain," passed at the last session of the Legislature. He went on to state in his letter - - *"The challenge before us now is to educate physicians and patients in West Virginia about this statute so that patients know to expect adequate pain management as part of their medical treatment."*

Recommendations

HB 4058 was passed on March 14, 1998, and will become effective in the middle of June. It received scant, if any, notice in the public media. It resolves many of the ambiguities and uncertainties that presently exist and allows a physician to exercise professional judgment in the area of pain management, without undue concern about how that judgment may be viewed in retrospect by, say, a podiatrist.

However, as Dr. Moss notes, there is a job to be done in educating physicians and patients with regard to the effects of this statute. Unfortunately, one cannot assume that this will automatically take place.

There are, of course, mechanisms where this change can be brought to the attention of physicians. However, I find it passing strange that the Board of Medicine never referred me at any point to this seminal piece of legislation. *(Perhaps they overestimated my research skills.)*

There is, I would suggest a danger that it will be "business as usual" for a long time. The scientific community has always been slow to accept change. Einstein, in his latter years, fought a rear-guard action against quantum mechanics, and Alfred Mirsky is now remembered only as the last major figure in cell biology to reject the idea that DNA is the molecule of heredity. Max Planck, who won the Nobel prize in 1918 for his work in quantum mechanics, said that established generations of scientists never accept new theories. "They die first."

A physician who chronically undermedicated patients for - - to use Dr. Brooks' phrase - - "fear of disciplinary action" can hardly be expected to overcome this phobia overnight, particularly when a changed behavior pattern might entail the risk of Board action.

The people who are seriously at risk now, however, are those patients with intractable pain who are being treated by timorous physicians and who end up suffering needless pain. It is these people who need to be educated as to their entitlement in medical care; these people and their families need to be advised as to their right to access to palliative treatment. If this is done, then I suspect that the free market economy will cure the problem of the timorous, Board-fearful physician.

The Law and Medicine Committee is uniquely qualified to perform this educative task. If this concept is approved, then I would suggest that a full complement of members be appointed to this committee and that contacts be initiated with the WV Board of Medicine, the Robert C. Byrd Health Sciences Center, the WV Department of Health and Human Resources, and the Attorney General's office, plus other interested persons and agencies to plan and implement an educational plan directed at informing medical consumers of their rights in this area.

(Please turn to the next page for an article by Dr. Alvin Moss regarding the Management of Intractable Pain Act.)

Special Report

The Management of Intractable Pain Act: What will it mean for physicians and patients in West Virginia?

ALVIN H. MOSS, M.D.
Professor of Medicine and Director of the Center for Health Ethics and Law, West Virginia University, Morgantown

GIL DELAURA, M.H.A., J.D.
Health Care Attorney, Charleston

BRIAN GALLAGHER, R.PH., J.D.
Legal Counsel, West Virginia University Hospitals, Morgantown

In survey after survey, the public reports that one of their top three concerns about end-of-life care is inadequate management of pain. Medical literature documents that the public's concerns are not unfounded. The well-funded and carefully analyzed SUPPORT study showed that 50% of patients experienced moderate to severe pain at least half the time in their last days of life (1).

Physicians also agree that patients are undermedicated at the end of life. In one large study of over 600 physicians in five hospitals in four states, 81% reported that "the most common form of 'narcotic abuse' in the care of the dying is undertreatment of pain." (2). In informal comments made at medical meetings, West Virginia physicians have also agreed that they have undermedicated patients who are in pain.

West Virginia physicians say they are reluctant to prescribe narcotics in large amounts because of fear of disciplinary action by the West Virginia State Board of Medicine. In effect, the threat of disciplinary actions by the Board of Medicine has been sufficient to discourage physicians from effectively treating patients' pain. Furthermore, the federal Controlled Substances Act of 1970 places on physicians and pharmacists a "corresponding responsibility" to ensure that controlled substances are prescribed and dispensed for "a legitimate medical purpose." In the past, this federal law has led to conservative prescribing and dispensing of controlled substances.

The purpose of the recently passed Management of Intractable Pain Act, HB 4058, that becomes effective in mid-June 1998 is to allow physicians to prescribe, nurses to administer, and pharmacists to dispense pain-relieving controlled substances for West Virginia patients with intractable pain, even in dosages in excess of the usual amounts, without fear of disciplinary action by their respective licensing boards. This new law should counter the tendency of physicians and pharmacists to be conservative with regard to controlled substances that had resulted from the 1970 federal law and should lead them to be more aggressive in pain management.

The law defines a pain-relieving controlled substance to include but not be limited to "an opioid or other drug classified as a schedule II controlled substance and recognized as effective for pain relief, and excludes any drug that has no accepted medical use in the United States or lacks accepted safety for use in treatment under medical supervision, including but not limited to any drug classified as schedule I controlled substance." The law defines intractable pain as "a pain state in which the cause of the pain cannot be removed. Intractable pain exists if an effective relief or cure of the cause of the pain (1) is not possible or (2) has not been found after reasonable efforts. Intractable pain may be temporary or chronic."

Passage of the new law encourages West Virginia physicians to practice medicine in accordance with the evolving standards for palliative care. The American Medical Association has written, "pain control medication should be employed in whatever dose necessary, and by whatever route necessary, to fully relieve the patient's pain" (3).

With regard to pain management, the World Health Organization suggests the following: "Freedom from pain should be seen as a right of every cancer patient and access to pain therapy is a measure of respect for this right" (4). In defining the standard of care for pain management, the Agency for Health Care Policy and Research (AHCPR) of the United States Department of Health and Human Services has issued two clinical practice guidelines, Acute Pain Management: Operative or Medical Procedures in Trauma, and Management of Cancer Pain. They recommend an ABCDE approach to pain management:

- **A** - *ask* about pain regularly, and assess pain systematically (ask the patient to rate the pain on a scale from 0, no pain at all, to 10, the worst pain imaginable);
- **B** - *believe* the patient and family in their reports of pain and what relieves it;

- **C** - *choose* pain control options appropriate for the patient, family, and setting;
- **D** - *deliver* interventions in a timely, logical, and coordinated fashion; and
- **E** - *empower* patients and their families (i.e., educate them), and enable them to control their course to the greatest extent possible (i.e., use patient-controlled analgesia)(5).

Physicians can obtain free copies of the AHCPR's guidelines for pain management by calling (800) 358-9295.

As physicians, we are obligated to relieve our patients' pain. The West Virginia Legislature has now made it easier for us to do it without fear of sanctions against us. Thanks are due to Delegate Vickie Douglas who introduced the bill in the House of Delegates, to Speaker Kiss and Minority Leader Robert Ashley who lead a bipartisan effort to sponsor the bill, and to House Judiciary Chair Rick Staton and Senate Judiciary Chair Bill Wooton who shepherded the bill through their committees to passage by their respective chambers of the Legislature. The responsiveness of West Virginia legislators to issues in health care has led West Virginia to have legislation on health care decision making for incapacitated patients, do-not-resuscitate orders, and now pain management years ahead of most states.

The West Virginia State Medical Association will assist in the effort to educate physicians about the latest techniques in pain management. For example, at the WVSMA's 1999 Mid-Winter Clinical Conference, which will take place from January 21-24 in Charleston at the Embassy Suites, one of the sessions will feature topics regarding the medical, ethical and legal aspects of pain management. Other educational programs will be offered in the future.

Patients in West Virginia will benefit now that physicians are freer from legal concerns and are becoming more knowledgeable about pain medicines and pain management techniques. With a concerted effort on the part of the medical community, fear of dying a painful death should no longer be a major concern of West Virginians.

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Malaria in West Virginia: Forty cases seen at West Virginia University Hospital

ARIF R. SARWARI, M.D., M.Sc.
Former Chief Resident of Internal Medicine, West Virginia University Hospital, Morgantown; Department of Medicine, Aga Khan University, Karachi, Pakistan

MELANIE FISHER, M.D., M.Sc.
Associate Professor of Medicine, Department of Medicine, West Virginia University School of Medicine, Morgantown

RASHIDA KHAKOO, M.D.
Professor of Medicine, Department of Medicine, West Virginia University School of Medicine, Morgantown

ERDOGAN GUNEL, Ph.D.
Professor of Statistics, Department of Statistics, West Virginia University, Morgantown

Abstract

In the U.S., malaria predominately occurs in travelers and immigrants. We report a series of 40 cases at West Virginia University Hospital, and 24 of whom were students who had visited areas of East Africa, West Africa and Asia usually in either December, January, August or September. Most patients (79%) reported a previous episode of malaria, and P. falciparum was identified in 60%. Fever, chills and rigors were the most common symptoms. Correct use of malaria prophylaxis was recorded in five patients, and only two of these were students. Successful outcomes were recorded in all but one patient. Our series suggests that international students would benefit from the proper use of chemoprophylaxis, thus decreasing the number of cases of malaria seen in university settings.

Introduction

Malaria is a serious protozoal illness affecting over 300 million persons worldwide. Up to 1 million deaths annually are attributed to this infection (1).

In the United States, malaria is predominantly a disease seen among travelers and immigrants. To date, most series have focused on cases of malaria seen in urban settings with large immigrant populations (2-4). Overall, case fatalities have ranged from one to two percent (5).

We present a series of malaria cases seen at West Virginia University (WVU) Hospital in Morgantown, W.Va., a city adjacent to many rural areas. Morgantown does not have a large immigrant population, but many international students attend WVU. Given recent clinical experiences, we hypothesized that the majority of cases would be among international students.

Our study examined the symptoms at presentation as well as the different treatment modalities used and their success. The appropriate use of chemoprophylaxis among the patients was also assessed.

Methods

WVU Hospital (WVUH) is a 350-bed tertiary care facility in Morgantown that serves a population of approximately 490,000 which includes the students at WVU, residents of the city itself, as well as individuals from adjacent areas in West Virginia, southeastern Ohio and southwestern Pennsylvania. WVU has an annual student population of 23,000 and approximately 1,000 are international students.

Following approval by the WVU Institutional Review Board for the Protection of Human Subjects, we retrospectively reviewed hospital records of all patients who were diagnosed with malaria over the past 25 years. A computer search of medical records was conducted using the diagnosis 'malaria.' The list was corroborated by simultaneous comparisons with information available from the section of Infection Disease case files, Infection Control records and Microbiology records of positive blood smears.

Malaria was diagnosed by the demonstration of the characteristic parasite on blood film. Species identification was made by an experienced microbiologist or infectious disease specialist. Cluster analysis using Ward's Error Sum of Squares Method was performed to identify similar time periods with respect to number of cases of malaria.

Results

A total of 40 cases of malaria were diagnosed from December 1967 to January 1993. Information on all 40 cases was retrieved and the results are shown in Table 1.

Of these 40 cases, 24 were students. Students with malaria were four times more likely to present during the months of December, January, August and September than during other times of the year (Figure 1).

Thirty-three of the 40 patients (83%) were males and 31 (78%) were under the age of 40. Nineteen patients listed Africa as their country of permanent residence with 11 in West Africa and eight in East Africa. Of the 15 U.S. residents, six were immigrants.

Table 1. Cases of Malaria Seen at West Virginia University 1967-1993.

Number	Presentation Date	Age (yrs.)/Gender	Ethnicity	Perm. Residence	Occupation
1	12/67	20/M	Caucasian	USA	Military Services
2	12/69	18/F	- -	USA	Student
3	12/69	20/M	- -	USA	Military Services
4	9/70	15/M	Caucasian	USA	Student
5	12/70	40/F	Caucasian	USA	Housewife
6	7/71	23/M	Caucasian	USA	Military Services
7	12/71	24/M	African	Tanzania	Student
8	9/74	26/M	African	Uganda	Student
9	11/75	1.5/M	African	Laos	- -
10	5/76	22/M	- -	Nigeria	- -
11	10/77	23/M	- -	Nigeria	- -
12	3/78	29/M	Asian	Kenya	Student
13	7/78	22/M	- -	Nigeria	Student
14	12/79	31/M	Caucasian	USA	Mine Inspector
15	1/80	30/M	African	Tanzania	Student
16	1/81	20/M	Asian	India	Student
17	4/81	22/M	Asian	India	Student
18	8/81	43/M	African	Gambia	Student
19	6/82	34/M	African	Tanzania	Student
20	8/82	36/M	African	East Africa	Student
21	1/83	33/M	African	Tanzania	Student
22	8/83	17/F	African	Ivory Coast	Student
23	8/83	32/M	African	Tanzania	Student
24	2/85	22/M	African	Nigeria	Student
25	5/86	11/M	Asian	USA	Student
26	6/87	58/F	Asian	India	Housewife
27	6/87	63/M	Asian	India	Retired
28	9/87	26/F	African	USA	- -
29	10/87	22/M	African	Nigeria	Student
30	9/88	24/F	Caucasian	England	Student
31	1/89	18/M	Caucasian	USA	Student
32	8/89	43/M	Asian	USA	Professor
33	1/90	31/M	African	Nigeria	Student
34	7/90	40/M	African	USA	Computer Operator
35	8/90	47/M	Caucasian	USA	Peace Corps
36	1/91	28/M	African	Ghana	Student
37	7/91	11/F	African	West Africa	- -
38	2/92	80/M	Asian	USA	- -
39	12/92	37/M	African	Ghana	Student
40	1/93	47/M	African	USA	Student

- - Information Is Either Not Available or Applicable

Country of Infection	Prior Case(s)	Length of Symptoms	Prophylaxis	Species	Treatment[1]
Vietnam	?One	7 days	- -	Vivax	C+P
Kenya/Tanzania	None	1 day	Chloroquine	Ovale	C+P
Vietnam	One	4-5 days	Chloroquine[2]	Vivax	C+P
Pakistan	None	8 days	None	Vivax	C+P
USA[3]	None	3 weeks	Not indicated	Vivax	C+P
Vietnam	- -	2 days	Chloroquine	Falciparum	Q+Py+D[4]
Tanzania	Multiple	1 day	None	Falciparum	Q+Py+D
Uganda	One (1973)	5 days	None	Falciparum	C
Laos	None	7-17 days	None	Falciparum	Q+Py+S
Nigeria	One (1975)	3 days	Chloroquine[2]	Falciparum	C
Nigeria	- -	- -	- -	Falciparum	C
Kenya/India	None	4 days	None	Vivax	C+P
Nigeria	Multiple	1 day	None	Falciparum	C
Multiple[5]	Two (1978/9)	4 days	Chloroquine	Vivax	C+P
Tanzania	Two (1973/8)	5 days	Chloroquine[2]	Falciparum	C
India	One (1976)	4 days	Chloroquine[2]	Vivax	C+P
India	- -	2 days	None	Vivax	C+P
Gambia	One (1977)	5 days	None	Falciparum	C
Tanzania	One (1980s)	2 days	None	Falciparum	Q+T[6]
East Africa	One (1978)	3 days	?[2]	Falciparum	C
Tanzania	Two (1982)	1 day	Chloroquine[2]	Falciparum	Q+Py+S
Ivory Coast	None	4 days	None	Falciparum	Q+Py+S
Tanzania	One (1982)	2 days	None	Ovale	C+P
Nigeria	One (1980)	3 days	None	Falciparum	C
India	One	4 days	- -	Vivax	C+P
India	- -	1 week	None	Vivax	C+P
India	- -	1 week	None	Vivax	C+P
Ivory Coast	One (1967)	6 days	None	Falciparum	Q+Py+S
Nigeria	One (1977)	2-4 days	- -	Ovale	C
Kenya	One (1988)	2 days	Proguanil[2]	Falciparum	Q+Py+S
Central Afr. Rep.	One (1989)	1 day	Chloroquine	Falciparum	Q+Py+S[7]
India	One (?1960)	5 days	Chloroquine	Falc. & Vivax	Q+Py+S+P
Nigeria	Multiple	1 day	None	Falciparum	Q+Py+S
Nigeria	Multiple	5 days	None	Falciparum	Q+Py+S
Mali	None	1 week	Chloroquine	Falciparum	Q+D
Ghana	Multiple	7 days	None	Ovale	C+P
West Africa	Multiple	4 days	None	Falciparum	C
Vietnam	- -	2 days	None	Vivax	C
Ghana	Four	2 days	None	Falciparum	Q+Py+S

[1] *C-Chloroquine, P-Primaquine, Q-Quinine, F-Fansidar, Py-Pyrimethamine, S-Sulfisoxazole, D-Dapsone, and T-Tetracycline.*
[2] *Chemoprophylaxis taken incorrectly or poor compliance.*
[3] *Malaria acquired through a blood transfusion.*
[4] *After no improvement on Chloroquine for two days.*
[5] *Zaire, Kenya, Tanzania, Zanzibar, Botswana, South Africa, Brazil, Venezuela, Columbia.*
[6] *Readmitted Dec 1982 with P. ovale (treated with Q+P) with no interim travel history.*
[7] *Regimen switched to Q+Doxycycline after development of leukopenia.*

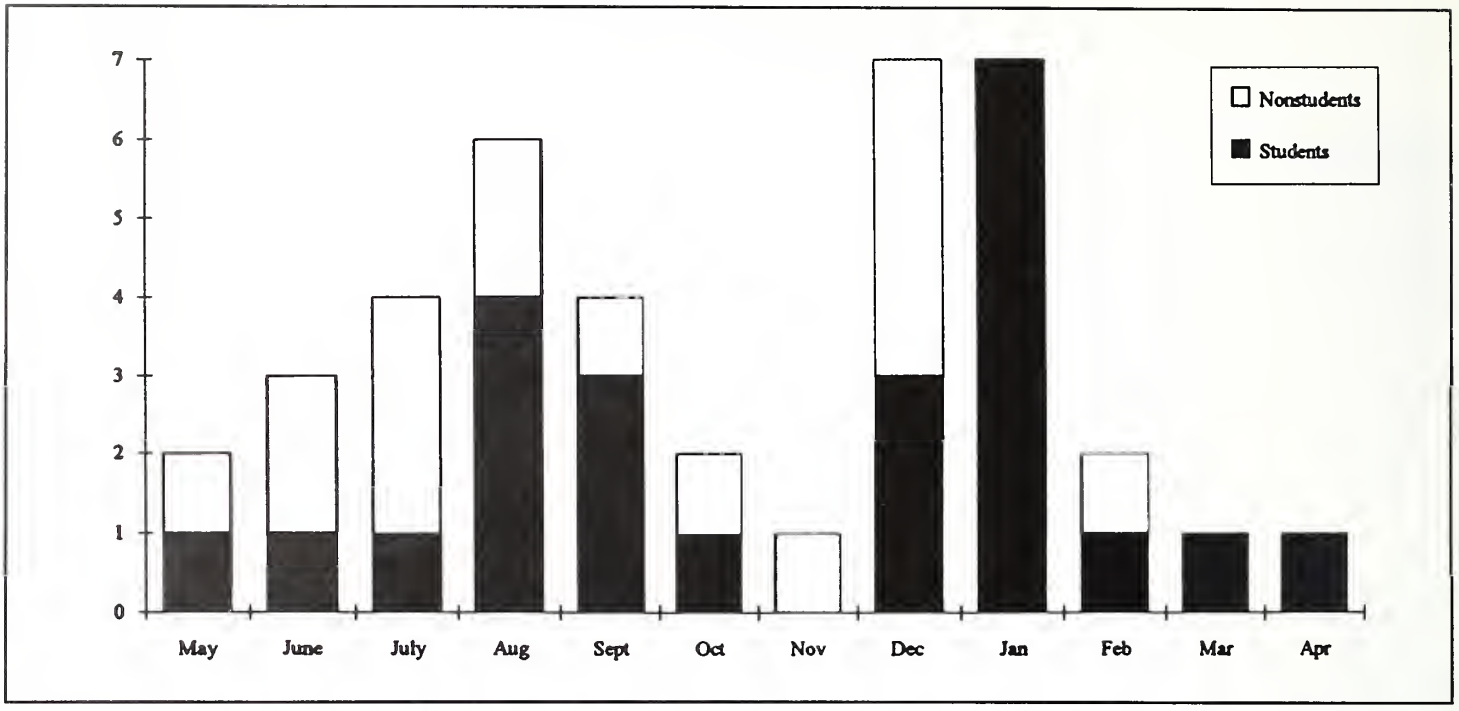

Figure 1. Illustration showing the 40 cases of malaria according to what month of the year they presented.

Among the 34 patients who listed an occupation, 24 (71%) were students and three were in the military services. While most of the students were exposed in East or West Africa, all three servicemen were exposed in Vietnam. One of the patients was a U.S. resident who had never left the country. She had acquired malaria through a blood transfusion traced back to a blood donation by a Vietnam veteran (6).

Africa and Asia were the two major sites of exposure to malaria. Twenty-seven patients (68%) had potential exposure to malaria in Africa; 15 in West Africa, 11 in East Africa and one in Central Africa. Thirteen patients (32%) were potentially exposed to malaria in Asia; eight in India or Pakistan and four in Vietnam or Laos. One patient traveled to South America in addition to West Africa. In the 34 patients where a reason for travel was identified, 27 (79%) were either returning to their home countries for a short visit or arriving in the U.S. to study. Only two patients acquired malaria while on vacation.

Table 2 represents the time period from the last potential exposure to the onset of symptoms in the 39 cases in which this was recorded.

Table 2. Time period from last potential exposure to onset of symptoms in patients with malaria.

Time	*P. falciparum*	*P. vivax/ovale*	Total cases
< 1 month	21	4	25
1 month - 1 year	2	10	12
> 1 year	0	2	2

Chi-square test for homogeneity with a p-value of 0.0001 indicates that there was a significant difference between the patients infected with *P. falciparum* and with *P. vivax* or *P. ovale* with respect to the time of occurrence of the symptoms. Symptoms occurred earlier in patients infected with *P. falciparum.*

Of the 34 patients for whom the information was available, 27 (79%) reported a previous history of malaria with 11 reporting more than one episode. In keeping with the otherwise general good health of these patients, no other significant comorbid medical conditions were noted except for an elderly man who was bedridden with severe Parkinson's disease.

Fever with chills and rigors along with headache, nausea, vomiting and myalgias were the most common presenting symptoms (Table 3). Sixteen patients (40%) had a palpable spleen on admission and nine (23%) had hepatomegaly.

Table 4 provides the laboratory parameters and shows that only four patients had hemoglobin less than 10 mg/dl. Seventeen patients had a white cell count below 5000/mm^3. A left shift (> 80% neutrophils or any number of band cells) was noted in 28 of 38 patients (74%). Fifty-six percent of the patients had a decreased platelet count. In addition, unconjugated bilirubinemia was noted in 16 of the 19 patients (84%) where levels were measured.

Table 3. Most common symptoms in the 40 malaria patients.

Symptom	Number of Cases	(%)
Fever	39	98
Chills and rigors	31	78
Headache	28	70
Myalgia	19	48
Nausea and vomiting	19	48
Arthralgia	9	23
Abdominal pain	8	20
Weakness	6	15
Backache	5	13
Diarrhea	4	10

**Most patients had more than one symptom.*

Table 4. Laboratory parameters in patients with malaria.

Parameter	Number of Cases	(%)
Hemoglobin less than 10 mg/dl	4/38	11
WBC count less than 5,000/ml	17/38	45
Platelet count less than 150,000/ml	18/32	56
Unconjugated bilirubin over 1 mg/dl	16/19	84

**The number of cases with the given laboratory value as a proportion of cases in which the test was performed.*

Only five of the 13 patients who took malaria chemoprophylaxis, took it correctly. Poor compliance was the main reason for incorrect use of chemoprophylaxis. Fifteen of the 22 (68%) who did not take any chemoprophylaxis were students. Malaria was the initial diagnosis on evaluation in the majority. Other preliminary diagnoses considered were 'fever of unknown origin,' otitis media, meningitis, hepatitis, pneumonia and an upper respiratory tract infection.

In all but one case, diagnosis was made after examining the peripheral blood smears. The exception was the patient with transfusion malaria who was transferred to WVUH with 'fever of unknown origin' where the plasmodium species was identified on a bone marrow smear. Twenty-four patients were infected with *P. falciparum*, 13 with *P. vivax* and five with *P. ovale*. (Two patients had two species each: *P. falciparum* and *P. ovale* in one and *P. falciparum* and *P. vivax* in the other.)

Twenty-six patients (65%) were treated with chloroquine, either alone or with primaquine. Fourteen patients (35%) were treated with combinations, most commonly quinine, pyrimethamine and sulfadiazine. Thirty-four of the 40 patients were managed as inpatients; 30 of them being discharged within the week.

No major complications were reported, but minor complications included transient thrombocytopenia, pancytopenia, leukopenia and cinchonism seen in one patient each. Severe nausea and vomiting occurred in two patients, one of whom required re-admission. One patient was treated for *P. falciparum* malaria with resolution of symptoms, but relapsed six months later with *P. ovale* malaria. He had no interim history of travel.

Good outcomes were recorded in all patients except for an 80-year-old patient with severe Parkinson's disease and concomitant malaria who died of aspiration pneumonia.

Discussion

Most of our cases of malaria were recorded in students. This may explain the tendency to see more cases in December - January and from August - September, periods that correlate with the return of overseas students for the start of a new term at the university or the arrival of new undergraduate or postgraduate students. A similar observation has been made from a previous series from Aberdeen (7).

Our patients were four times more likely to present during these periods. East Africa, West Africa and Asia were the commonest areas of exposure. Not surprisingly, an overwhelming majority (79%) of patients reported previous episodes of malaria and some in fact presented with complaints of 'I've got malaria again.' This may have contributed to the high index of suspicion for malaria on initial evaluation among most of our patients. Early clinical suspicion and initiation of therapy were, in our opinion, significant contributors to the low fatality rate.

Patients developed symptoms earlier if infected with *P. falciparum*. This fact can be explained by the tendency of the *P. falciparum* parasite to develop its pre-erythrocytic stage more rapidly. Fever, chills and rigors were the commonest presenting symptoms with a wide variety of other symptoms that could easily be misinterpreted as consistent with 'viral infection.' One patient was referred by a physician in a rural area to WVUH with a 'viral illness' despite a significant travel history. The need for a very high degree of suspicion in any patient with fever and a history of travel to malarious areas and familiarity with the disease by primary care physicians cannot be overemphasized.

Few of our patients had a significant degree of hemolysis and none had complications of *P. falciparum* malaria. This may be due to the past experience with malaria infection in the majority of patients with the possible retention of partial immunity. This may also account for the generally good outcomes and low complications despite the identification of *P. falciparum* in 60% of the patients.

Although most cases were in patients with a previous history of malaria, few patients had taken anti-malarial prophylaxis correctly, if at all. This finding underscores the need for education of individuals who have lived in non-endemic areas for a while and are returning to their homeland areas endemic for malaria. Immunity wanes over time and this is a group that requires use of chemoprophylactic drugs. Few recognize the potential severity of an illness they may have had multiple times in the past and that for the most part was previously treated by medications available over the counter.

Such nonchalance may have lead to avoidable fatalities reported in literature (8). Among patients who took anti-malarial prophylaxis correctly, infection was either with suspected resistant stains of *P. falciparum* or due to the lack of use of primaquine to eradicate the extra-erythrocytic stages of *P. ovale* and *P. vivax*.

Chloroquine was the predominant drug used for prophylaxis. However, it is now recognized that travel to most of Africa and Asia is associated with exposure to resistant strains of *P. falciparum* with the need for Mefloquine prophylaxis (9,10). Doxycycline may be required for prophylaxis in areas with multidrug resistance such as Thailand.

To receive the most up-to-date information, physicians and travelers should contact the Centers for Disease Control and Prevention's International Travelers Hotline at (404) 332-4559. The CDC also publishes an excellent reference yearly which is entitled *"Health Information for International Travel"* (11).

Conclusions

With the current ease of travel, malaria can be seen anywhere in the world. Thus, all physicians need to be familiar with the disease.

The diagnosis of malaria requires a high index of suspicion in anyone with a febrile illness and a history of travel to an endemic area. Patients from endemic areas living in the United States for a period of time need to take chemoprophylaxis just as a first time traveler to an endemic area. With the spread of resistant strains of *P. falciparum* worldwide, physicians need to remain aware of current recommendations for chemoprophylaxis and treatment.

We suggest that international students returning from vacations to their homelands make up a significant proportion of cases of malaria seen at university hospitals similar to ours in the U.S. Specifically educating this group for the need and correct use of chemoprophylaxis may help decrease the cases of malaria seen in these settings.

Acknowledgement

We wish to acknowledge Mrs. Susan Jackson for all of her assistance in the preparation of this manuscript.

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A case report of idiopathic pulmonary ossification

SALAM RAJJOUB, M.D.
Pulmonary and Critical Care Fellow, University of Louisville, Louisville, Ky.; Former Chief Resident, Internal Medicine, Ohio Valley Medical Center, Wheeling, WV

ROBERT B. ALTMEYER, M.D.
Chairman of Pulmonary Medicine Subsection, Ohio Valley Medical Center, Wheeling; Medical Director, Respiratory Care Department, Wheeling Hospital

Abstract

Idiopathic pulmonary ossification is a rare disease. Most commonly, it affects middle-aged men. Its etiology is unknown. We present a case of nodular type idiopathic pulmonary ossification in a 42-year-old, white male who had one episode of hemoptysis.

Introduction

Idiopathic pulmonary ossification (IPO) is a disease of unknown etiology in which mature bone, often containing marrow, is found in pulmonary parenchyma (1). IPO usually affects men ages 40-60, but a few cases have been reported in women. Fewer than 100 cases have been reported since Luschka's first description in 1856, and the first American case of IPO was not reported until 1968 (1,4).

Symptoms or signs of IPO are rare. Serum calcium, phosphorus and alkaline phosphatase are normal (1), but pulmonary function tests may show a restrictive pattern with low diffusion capacity (4). There are two types of pulmonary ossification. The first type is dendriform, which branches along terminal airways with occasional islands of marrow. The second type is nodular, which tends to be more circumscribed and situated in alveolar spaces (2,5).

The lesions of IPO occur bilaterally in the lower lobes of the lungs. Chest X-rays usually show either fine linear shadows 1-4 mm thick arranged in a branching (dendritic) pattern, or a small punctuated nodular pattern (1,2).

IPO should be suspected when a patient with no known pulmonary or cardiac disease has very few respiratory symptoms compared to the findings on chest X-ray. To confirm the calcifications in areas corresponding to the abnormalities on the chest X-ray, a bone scan with hydroxymethylen diphosphate should be performed (6,7). Finally, definite diagnosis of IPO should be done by open lung biopsy.

There is no known treatment for IPO. Also, there is no evidence that restriction of calcium intake, EDTA, corticosteriods, or biphosphonate causes regression (8).

Case report

A 42-year-old white male was referred by his family doctor because he had experienced one episode of hemoptysis, and a chest X-ray had indicated nodular interstitial markings (Figure 1).

Figure 1. The patient's chest X-ray showing nodular interstitial markings.

Figure 2. **Patient's normal chest X-ray taken in 1988.**

Figure 3. **CT scan of the chest showing thickening of the bronchial wall and micronodularity of the lung paranchyma.**

When we saw the patient, he was asymptomatic. His past medical history included removal of basal cell cancer of the scalp in 1989, vasectomy in 1981, and tonsillectomy as a child. His family history was positive for emphysema in his father. In addition, he denied any previous heart disease lung disease or cigarette smoking.

During the physical exam, he appeared to be well nourished and well developed. There were no signs of respiratory distress. His pulse was 60 and regular. His blood pressure was 120/76. Auscultation of the lungs was normal as was the rest of his physical examination.

In 1988, this patient had a chest X-ray which was normal (Figure 2). His laboratory work including blood count, electrolytes, coagulation, bleeding time, RF, ACE and ANA were also within normal limits. However, the patient also underwent a CT scan of the chest which showed thickening of the bronchial walls and micronodularity of the lung paranchyma (Figure 3).

The PFTs done on 6/13/94 showed no restrictive or obstructive pattern. Diffusing capacity and arterial blood gases were also within normal limits. A bronchoscopy done on 6/1/94 was inconclusive. On 7/5/94, the patient underwent thoracotomy, and the lung biopsy showed idiopathic pulmonary ossification, nodular type with marrow elements (Figure 4). On 7/7/94, an echocardiogram was done which showed that PA pressures, mitral valve and LV function were normal.

This patient is still doing well and is asymptomatic. A chest X-ray and DLCO is being performed on him every year for followup.

Figure 4. **The lung biopsy shows idiopathic pulmonary ossification, nodular type with marrow elements.**

Discussion

IPO is a slowly progressive disease that usually affects middle-aged men. Its etiology is still unknown. However, there have been many theories regarding the pathogenesis of this disease.

One theory states that the typical branching form of IPO occurs in association with idiopathic interstititial fibrosis (1,3). The second theory claims that since mitral stenosis can cause pulmonary ossification, venous stasis could be associated with IPO (1,3,5). The third theory suggests that repeated infection of the lungs due to tuberculosis or histoplasmosis can trigger the ossification process. The fourth theory suggests a relationship between amyloid deposits (such as in hemodialysis) in the lungs and IPO (1,3). The fifth theory proposed by Propilka and Kleinerman claims than an anoxic and acidic environment from any cause in the lung triggers fibroblasts to undergo transformation to osteoblasts and slowly cause ossification in the lungs (2,3,4).

The final theory states that there have been case reports of pulmonary ossification associated with chemotherapy such as Busulfan, cystic fibrosis, asbestosis, acromegaly and myositis ossificans (1,4). None of the above etiologies were found in our patient.

Conclusion

Unfortunately, there is no known treatment for this slowly progressive disease. Low calcium diets, corticosterioids and binders of calcium have not been proved to be helpful. However, disodium etidronate may be helpful in the prevention of further ectopic bone formation, but there is no long-term study to prove its efficacy (9).

The authors suggest studying the long-term effects of biphosphonates on IPO patients.

Acknowledgement

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Utilization of diagnostic resources for meningoencephalitis in the pediatric ICU

JOSE IRAZUZTA, M.D.
Director of Critical Care Medicine, Children's Medical Center, Dayton, Ohio; Associate Professor of Pediatrics, University of Cincinnati, Cincinnati; Former Associate Professor of Pediatrics, Robert C. Byrd Health Sciences Center of West Virginia University, Charleston Division; and Former Medical Director, Pediatric ICU, Women and Children's Hospital, Charleston

BARBARA ALLEN, M.D.
Former Medical Student, Department of Pediatrics, Women and Children's Hospital, Charleston

FOREST ARNOLD, D.O.
Intern, Charleston Area Medical Center, Charleston

JIANLIANG ZHANG, PH.D.
Former Biostatistician, Charleston Area Medical Center, Charleston

Abstract

To determine whether a Pediatric Critical Care team has an evolution of medical practice that decreases the utilization of diagnostic tests and consults, we examined the records of 69 patients admitted for meningitis or meningoencephalitis at Women and Children's Hospital in Charleston, W.Va., a university-affiliated, teaching hospital. The study was conducted from August 1990 to August 1994. We found that utilization of diagnostic resources (UDR) decreased over the four years, and there was a direct relationship between an increase in severity of illness and an increase in UDR. When adjusted per severity of illness, UDR decreased by $423 per year. The presence of a consult was a factor leading to an increase in resources, which were associated with an increased utilization of diagnostic tests and length of stay. The consultation rate was independent of the severity of illness and experienced a decrease over the years.

Introduction

The increase in health care expenditures has been a growing source of concern in the United States (1,2,3). Since ICUs consume more than 22 percent of total hospital costs, their management has a significant impact in the provision of health care (4,5,6).

Coordination of the ICU by a critical care practitioner increases the effectiveness of its management (7,8), improves outcome (9), and also leads to increased exposure to a patient population giving the attending the opportunity to accumulate experience (10,11). We hypothesized that as experience is gained, the ability to manage patients utilizing fewer resources to complement clinical judgment should increase. Thus, this evolution of medical practice should be reflected in the management of conditions for which there are no set protocols, and consequently, in the cost of health care provision.

We tested our hypothesis by utilizing the charges generated by critical care physicians' requests for diagnostic tests and consultations as an indicator of resource utilization for a homogeneous group of patients.

Materials and methods

In August 1990, a pediatric intensivist assumed the role as full-time medical director of the Pediatric Intensive Care Unit (PICU) and introduced changes in the unit's organization. Patients were admitted to a pediatric critical care team, led by pediatric intensivits and senior residents, who were in charge of coordinating management and writing all orders.

None of the PICU physicians (four) had prior experience as attendings under this system. Multidisciplinary team care rounds were conducted in the morning with other specialists, nurses and respiratory therapists and then evening rounds with residents. No guidelines or protocol for management were in place, nor were cost containment strategies. The call system was on a rotation basis, with each attending on call 3-5 successive days at a time. Standing lab orders were discouraged and if present they were time limited.

Charts from patients admitted to the PICU from August 1990 to August 1994 were examined. Data from children diagnosed with meningitis or meningoencephalitis admitted for decreased level of consciousness and/or seizures were included. Individuals with signs of shock or immuncompromise were excluded. Relevant data included age, severity of illness (SI) assessed as the probability of death calculated from a physiological score of instability (Pediatric Risk of Mortality Score using data from the initial 24 hours), PICU length of stay and year of admission.

Resource utilization was estimated as patient-specific PICU charges generated from physicians' requests for diagnostic purposes and labeled as utilization of diagnostic resources (UDR). Diagnostic charges were calculated applying the charges in 1994 for all laboratory tests, X-rays and neurologic studies (CT, MRI and EEG) including interpretation fees and consultation fees. The total hospital bill for each patient was retrieved and prorated by the percentage increase that the Health Care Cost Review Authority (HCCRA) has authorized for each year.

Statistics

Simple or multiple regression analysis was used to analyze the association between variables. Analysis of Variance was used to

compare means of multiple groups while Analysis of Covariance was performed if both continuous and categorical explanatory variables were included.

Logistic regression was employed to analyze the likelihood of an event as predicted by other factors. A p value of $< .05$ was considered statistically significant. Throughout the statistical analysis, the logarithm of estimated mortality rate was used to correlate with other variables.

Results

During the study period, 69 patients fulfilled the inclusion criteria, representing 5.6 percent of PICU admissions. All patients survived.

Average values for age, SI, length of stay and proportion of meningitis vs. meningoencephalitis was not significantly different over the years. The percentage of patients who had a consult, the frequency that neurologic studies were obtained, and average expenditure for lab tests per patient decreased over the years (Table 1).

The mean for UDR was $2,832 (range $582 to $8,200), and Figure 1 shows the percentile distribution per year. Lab tests represented 64 percent of UDR, X-rays and neurological studies (with interpretation fees) representing 33%, and consultation fees representing three percent. The average hospital charge was $11,625 (range $3,779 to 27,039). The calculated charges generated by physicians' fees for consultation or interpretation of tests represented 11 percent of UDR and were billed separately from the hospital bill. When these physicians' fees were discounted from UDR, the remaining charges represented 22 percent of the prorated hospital bill.

Diagnostic Resources and Severity of Illness: The UDR were found to be directly related to SI ($p = .001$, $r^2 = .15$) (Figure 2). The slope of this relationship, when years were analyzed individually, was not significantly different (interaction of year and SI had a p value of .8)

Table 1. Data From Patients with Meningitis and Meningoencephalitis.

Year	1990	1991	1992	1993	1994
Patients	7	19	21	16	6
Age	87 (71)	73 (59)	71 (44)	59 (65)	64 (62)
MR	0.04 (0.07)	0.02 (0.01)	0.03 (0.04)	0.02 (0.02)	0.02 (0.01)
PICU Days	2.8 (1.2)	2.8 (1.3)	3.1 (1.5)	2.2 (1.0)	2.8 (1.4)
Men/Ence	2/5	6/13	3/19	6/10	2/4
Consults	42%	52%	28%	18%	16%
Lab $	1,821	2,275	2,078	1,059	1,380
NS/Pt	1.7	1.2	1.3	0.9	0.6

Age, in months; MR, risk of mortality (PRISM); PICU days, length of stay in the PICU. These are shown as mean and standard deviation (in parenthesis).

Men/Ence, # of cases with meningitis/number of cases with meningoencephalitis; Consult, percent of patients with a consult ($p = .003$, odd ratio .6), Lab $, mean of expenses for laboratory tests per patient per year; NS/Pt, neurologic studies per pt (CT, MRI, EEGs/number of patients)

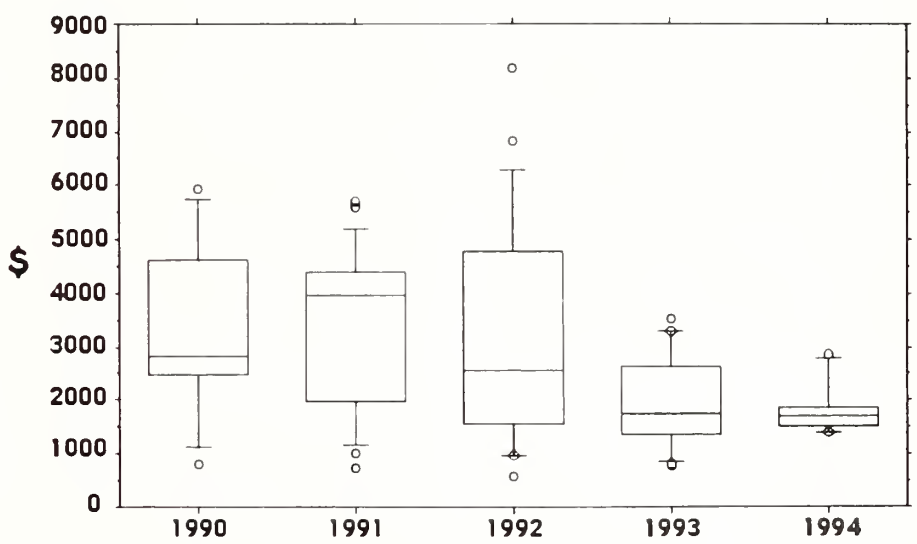
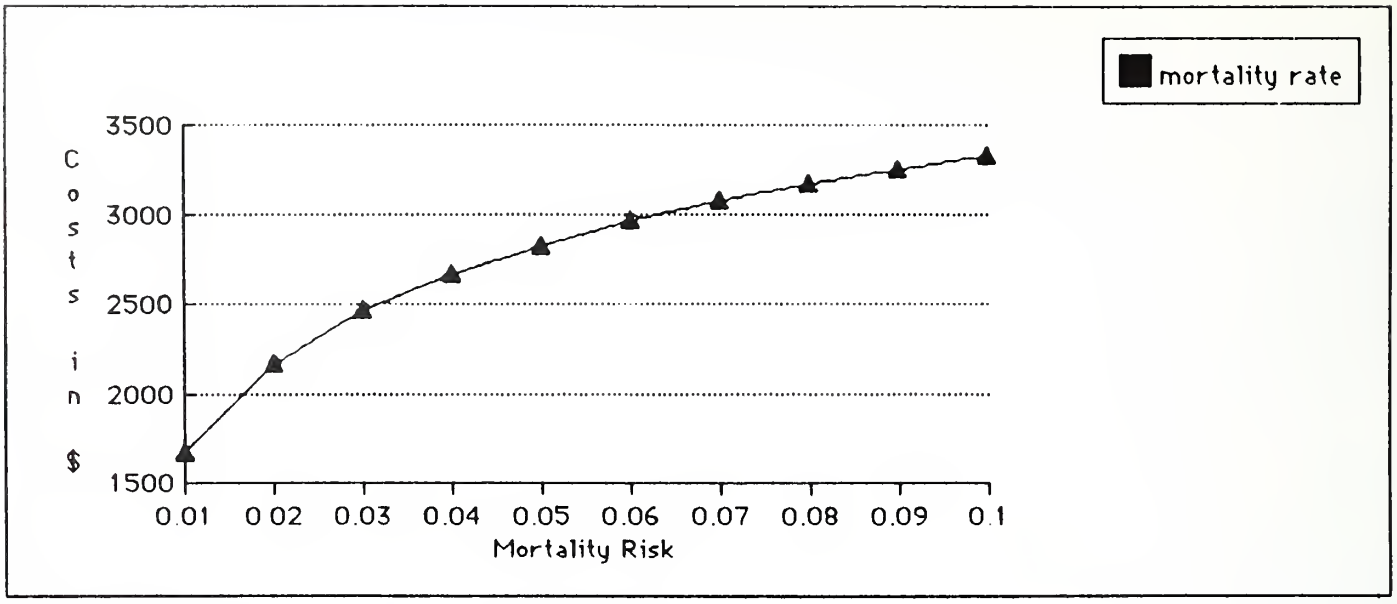


Figure 1. The yearly percentile utilization of diagnostic resources.

Upper bar 25th percentile
Lower bar 75th percentile
(o) outliers

Center bar 50th percentile
10th and 90th percentile



Graph constructed using a general linear model procedure ($p = .001$).

Figure 2. Estimated changes in utilization of diagnostic resources in relation to risk of mortality.

Diagnostic Resources and Year of Admission: The UDR decreased over the years (p = .007, $r^2 = .11$). When adjusted by SI in a linear regression model, UDR still decreased over the study period (for year p = .01, coef - $423). Utilizating the three percent mortality risk (mean of the group), the estimated UDR decreased from $3,915 in 1990 to $2,222 in 1994.

Utilization of Consultations and Its Implications: The presence of a consultation was related to the year of admission: a linear regression analysis demonstrated a decrease over the years (p = .03, coef -.10). No correlation was found between SI and the presence of a consultation on the case ($p = .8$, *odd ratio .9*).

Since consultation fees represent a portion of the UDR, we discounted this from the UDR. These adjusted charges had a direct relationship to the presence of a consult on the case. The presence of a consultation, adjusted per SI and year of admission, was associated with an increase in resource utilization with a calculated charge of $1,424 ($p = .0001$) and an increase in the PICU length of stay of 1.7 days ($p = .0002$).

A direct correlation ($p = .002$) between the presence of a consultation and an increase in laboratory utilization (estimated at $870) was also detected. The frequency of neurological studies was directly related to the presence of a consultation on the case ($p = .0002$, $r^2 = .19$). The likelihood of having a neurologic study was .83 (N46) for patients without a consult versus 1.91 (N23) with a consult ($p = .0002$).

Discussion

Utilization of diagnostic resources were the sum of all diagnostic expenditures for each individual patient. Three variables were found to be related to UDR: SI, reflecting a logical increase in resource utilization for sicker patients. This relationship has been found by others regardless of the disease process (12).

It is noteworthy that UDR decreased over the years. Interestingly, the utilization of consultations did not correlate with patient characteristics such as age or SI, but did correlate with the year of the patient's admission. Fewer requests for consultation was an independent factor of decreased utilization in other diagnostic resources. All consultations were ordered in the first 24 hours and were not related to patient complications during the PICU stay. Patient-specific resources were driven by the involvement of a consultant. Its presence was an indirect cost-driver secondary to an increased use of tests and an increase in length of stay.

Prior to the study period, the PICU did not have regularly scheduled team rounds. Consultants assessed the patient and gave orders with no coordinated interaction with the PICU attending. Decisions were passed to the respiratory therapist and nurses. In our case, changes in the centralization of care and a multidisciplinary approach were just being introduced at the beginning of this study. This was a newly restructured PICU with young intensivists learning their function as team leaders.

Patients with meningitis (without sign of septic shock) and meningoencephalitis (mainly La Crosse encephalitis) were admitted for a decreased level of consciousness and/or seizures and had similiar clinical courses. No new treatments were implemented during the study period. Patients

with herpetic encephalitis or patients with intracranial pressure monitors were excluded. There was a learning process from the PICU attendings toward understanding and managing La Crosse encephalitis, which is endemic to the area (13), and meningeal inflammation. Multiple teaching sessions for residents and nurses were also offered by the PICU attendings as experience because experience was gained.

The medical director stipulated that interaction during morning rounds with all caretakers was essential. The physicians had no prior experience as attendings in this team-led centralized system. Three of the attendings acquired board certification in Pediatric Critical Care during the study period and another began the grandfather process.

For the physicians involved, we believe that confidence in the patients' management was gained as the team leaders had more opportunities to be exposed to this group of patients. Progressively, there was less need to complement clinical judgement with lab tests, imaging studies or consultations. No explicit or implicit cost containment policies were implemented that may have prevented attendings from managing their patients as desired.

By retrospectively analyzing the PICU requests for diagnostic tests or consultations, a pattern reflecting the management and learning curve of the PICU team leaders can be visualized. While some studies have focused on the impact of invensivists or a care team (7,8,9,14,15), we are not aware of studies that explore the evolution of their management. Our findings indicate that physicians may utilize fewer resources as experience is acquired. This argues in favor of centralization of the intensive care decision process to promote experience, and emphasizes the importance of improving conditions for ICU attendings in order for them to remain in this role for many years (16).

Even though this is a micro-economic evaluation of a small component of the expenses originated in an ICU, it is one mainly origninated from physicians in charge of the care of patients and represents 22 percent of the hospital bill. Charges are often inflated by hospitals, and thus, do not reliably represent their expenditures; but within the same setting it is fair to use them as a unit of measurement for resource utilization.

Conclusion

A decrease in utilization of diagnostic resources over the years was detected. These data suggest that PICU attendings in this centralized, coordinated approach have a learning curve that reflects cost effectiveness.

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(Please contact first author for other references listed in this manuscript.)

Second Session to focus on managed care's impact on medical education; CME issues

This year's Second General Session on Friday, August 28 at 9 a.m. during the WVSMA's Annual Meeting at The Greenbrier will feature a lecture about how managed care is affecting medical education, as well as two presentations on current topics about continuing medical education licensure, regulations and sponsors.

Robert D'Alessandri, M.D., vice president for health sciences and dean of the West Virginia University School of Medicine, will begin this session with his presentation entitled *"Beyond Medical School: Managed Care's Impact on Education."* Immediately following, **Albert N. May, M.D.**, chairman of Ohio State Medical Association's Committee on Accreditation for CME Sponsors, who is a member of the Board of Governors for the Alliance for CME (ACME) and a councilor for the Accreditation Council for CME (ACCME), will discuss *"The Role of State Medical Societies in the Evolving Climate of CME As We Approach the New Millennium."*

After a brief break, this session will reconvene with a lecture entitled *"Continuing Medical Education and State Licensure"* by **Gerald J. Bechamps, M.D.**, a surgeon at Winchester Surgical Clinic in Winchester, Va., who is a past president of both the Virginia State Board of Medicine and the Federation of State Medical Boards, and a member of the National Board of Medical Examiners. At the conclusion of Dr. Bechamps' lecture, the three speakers will participate in a Q & A session with **James D. Helsley, M.D.**, the chairman of the WVSMA's Committee for Medical Education, who will be moderating.

D'Alessandri

May

Bechamps

Bios on Drs. D'Alessandri, May and Bechamps begin below. A registration form, as well as other information about this year's Annual Meeting, are published in this issue beginning on page 154.

For more details, phone the WVSMA at (304) 925-0342.

Speakers highlighted

Dr. D'Alessandri is a graduate of Fordham University and NY Medical College. A specialist in infectious diseases and general medicine, Dr. D'Alessandri completed postgraduate training at Metropolitan Hospital in NY and the University of Florida.

Dr. D'Alessandri has long been active in health policy issues nationally and in West Virginia. He is a regular guest commentator on West Virginia Public Radio and appears each week as a medical correspondent on television news programs in Wheeling, Clarksburg, and Charleston. He also hosts *"Doctors on Call,"* a live public TV broadcast that addresses a different health topic each week, answering questions phoned in by viewers throughout West Virginia and in parts of Pennsylvania, Ohio, Maryland and Virginia.

In addition to his roles at the WVU School of Medicine as vice president for health sciences and dean, Dr. A'lessandri is a member of several national medical education groups. He has served on the executive committee of the Accreditation Council for Graduate Medical Education as a representative of the American Association of Medical Colleges, and as chair of the Accreditation Council for Graduate Medical Education. He was the recipient of the 1993 Medical Executive Award of the American College of Medical Group Administrators (ACMGA).

Dr. May is a graduate of Hahnemann Medical College and the Hospital of Philadelphia. He completed his internship and pediatrics residency at Packer Hospital and Guthrie Clinic in Sayre, Pa.

Currently in private practice for pediatrics and pediatric allergy in in Marion, Ohio, Dr. May is a

clinical associate professor of pediatrics at Ohio State University College of Medicine. He lectures frequently on the subject of CME and has been a visiting professor at several universities.

Dr. May often serves as a consultant on CME programs for state medical associations, hospitals, medical colleges, foundations, and managed care organizations. In addition to serving as chairman of the Ohio State Medical Association's Committee on Accreditation for CME Sponsors, as a member of the Board of Governors for the Alliance for CME (ACME), and as a councilor for the Accreditation Council for CME (ACCME), Dr. May is the editor of the Continuing Medical Education Procedures Manual for the OSMA.

Dr. Bechamps received his M.D. degree from Georgetown University School of Medicine in 1963. He completed an internship and surgical residency at Meadowbrook Hospital in East Meadow, N.Y., and then was on the staff at the Mayo Clinic & Foundation for four years with a general surgery fellowship.

From 1964-1971, Dr. Bechamps served in the U.S. Army Reserves and was named a major in the U.S. Army Medical Corps from July 1969 until July 1971. During these two years he held posts as chief of the General Surgery Dept. at McDonald Army Hospital in Fort Eustis, Va.; and as a general surgeon at the U.S. Army Dispensary in Fort Sheridan, Ill., and Kimbrough Army Hospital in Fort Meade, Md.

Since 1971, Dr. Bechamps has been a general surgeon at Winchester Medical Center in Winchester, Va., and since 1984 he has also served as a general surgeon at the Surgi-Center of Winchester. During his years at Winchester Medical Center, Dr. Bechamps held numerous leadership roles and committee posts including president of staff and chief of the Department of Surgery.

A member of the board of directors of the National Board of Medical Examiners and of the USMLE Step-3 Committee, Dr. Bechamps is a past president of the Virginia State Board of Medicine and of the Federation of State Medical Examiners.

Flink Address to focus on past 50 years of medicine

Robert J. Marshall, M.D., of Huntington, a specialist in internal medicine, will deliver this Edmund B. Flink Address at the WVSMA's Annual Meeting on Saturday, August 29 at 9:30 a.m. during the Second Session of the House of Delegates. His lecture is entitled *"1948-1998: A Retrospective."*

Dr. Marshall was born in Ballymena, Northern Ireland. He graduated with honors from the Queen's University in Belfast in 1948, where he received bachelor degrees in medicine, surgery and obstetrics.

After an internship, Dr. Marshall served for three years as an instructor in the Departments of Physiology and Anatomical Pathology at Queen's, where he also completed residency and fellowship training in internal medicine and cardiology, and earned his doctorate of medicine degree. In 1957, Dr. Marshall became a research fellow at the Baker Institute and Melbourne University in Australia, where he published some of the earliest studies about vascular reactivity in hypertension and the antihypertensive and diuretic actions of chlorothiazide.

Marshall

Following his fellowship, Dr. Marshall was awarded a Fulbright Fellowship and spent three years at the Mayo Clinic as an assistant professor in the Section of Physiology and Biophysics. In 1961, he moved to West Virginia to become one of the founding faculty of the WVU School of Medicine, where he taught for 15 years, serving as a professor and chairman of the Division of Cardiology and as a professor of physiology.

In 1976, Dr. Marshall moved to Huntington to join the practice of Huntington Internal Medicine Group, where he still practices on a consulting basis. During his career in Huntington, Dr. Marshall helped to develop the initial facilities at St. Mary's Hospital for cardiac catheterization and open heart surgery and taught at the Marshall University School of Medicine.

A fellow of both the Royal College of Physicians in London and the Royal College of Physicians of Ireland, Dr. Marshall recently completed a four-year appointment as governor of the West Virginia Chapter of the American College of Physicians. Last year, Dr. Marshall was named a master of the American College of Physicians.

REGISTER TODAY
for the
WVSMA Annual Meeting!

Turn to Page 154
or phone the WVSMA at (304) 925-0342

Over 160 pathologists, cytotechnologists from U.S., Canada, Europe attend annual fund-raising seminar

Participants at the Fifth Annual Seminar in Pathology listen to a lecture.

This year, 161 pathologists and four cytotechnologists from the United States, Canada and Belgium participated in the Fifth Annual Seminar in Pathology which is sponsored by the United Hospital Center (UHC) and held at Pittsburgh Marriott City Center to raise funds to benefit Health Access, a free clinic in Clarksburg.

Since the seminar was first conducted in 1994, it has raised about 100,000 for Health Access, and grown tremendously in attendence. Dr. Chinmay K. Datta, a pathologist who organizes and conducts this seminar, commented that this year about 70 participants repeated the course which is an indication of its increasing popularity.

"Participants have commented that this is a very well organized, top-of-the-line medical education course given by nationally and internationally known speakers," Dr. Datta said. "Some of the participants have also stated that this course is even better than many of the nationally held courses and they intend to come back next year. This year we were able to donate $22,000 to Health Access," he added.

During the seminar, Bruce Carter, CEO and president of UHC, addressed participants about the continuing need to raise fund for Health Access, which was created in 1992 to serve people who do not have health insurance.

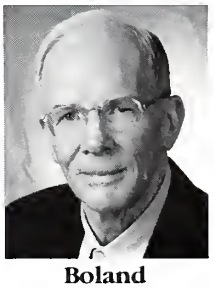
Other individuals who helped with the seminar included WVSMA Alliance member Subhra Datta, a member of the board of Health Access; Joanne Parks, laboratory technologist at UHC; Suzanne Hornor, director of public relations at UHC; and Sam Ellis, UHC auxiliary volunteer.

Four physicians named clinical directors at Charleston Area Medical Center

Four physicians have new duties as clinical directors at Charleston Area Medical Center, representing the latest partnership between doctors and administrators that affect the entire hospital.

Dr. Constantino Y. Amores has been named clinical director of the Neurology/Orthopedics/Trauma Services Group; Dr. James P. Boland is the clinical director for the Cardiovascular/Surgery Services Group; Dr. Paul H. Fulcher Jr. has been named clinical director for the Women & Children's Services Group; and Dr. Greg Rosencrance is the new clinical director for the Internal Medicine/Family Practices Service Group.

Amores



Boland

Fulcher

Rosencrance

Cardiology meeting set

The American College of Cardiology will present *"New Techniques and Concepts in Cardiology"* at the Capitol Hilton in Washington, D.C., on October 22-24.

A total of 16 Category 1 AMA CME credits will be offered.

For more information, phone the ACC at (800) 253-4636, ext. 695, or FAX (301) 897-9745.

Correction

In the scientific article *"Listeria monocytogens rhomboencephalitis with cranial-nerve palsies: A case report"* in the March/April issue, the cranial nerve identified in Figure 4 should be VII, not VI.

Insurance experts suggest care in selecting your malpractice carrier

Without a doubt, facing a malpractice lawsuit is one of the most traumatic moments in any physician's career. Imagine, though, facing the suit without the protection or assistance of your malpractice carrier, even though you've paid them tens of thousands of dollars.

Hundreds of West Virginia physicians face that prospect now that PIE has been taken over by regulators in Ohio. Should physicians have seen it coming? Insurance experts say the signs were there, citing PIE's falling ratings from A. M. Best, one of the nations' largest providers of financial stability ratings.

Can it be prevented in the future? Again, insurance experts say yes. They suggest the following precautions when evaluating a professional liability carrier:

- **Check the insurer's ratings.**
  If A. M. Best or Standard & Poors are lowering their ratings, if their ratings are below A to begin with, or there is a "negative outlook" on the company, trouble may be brewing. On the other hand, an upgrade in ratings should give you cause for comfort.
- **Evaluate any proposals you receive carefully.**
  Is the carrier promising "penthouse protection at bargain basement rates? You really do get what you pay for when it comes to malpractice insurance, so a carrier that's selling below the market may be trying to buy your business with plans to dramatically increase rates later, or they may be setting themselves up for financial disaster.
- **Do your own homework on the company's financial strength.**
  Get a copy of the company's annual report and SEC filings. Reading those will give you a feel for the company's operating philosophy and commitment.
- **Find out which company is most committed to the defense of your claims.**
  Ask the leading malpractice defense attorneys in your area which companies really fight claims, and which ones prefer to settle - - even though they talk about defense.
- **Find out if you retain true consent to settle rights in your policy.**
  Many companies say you retain those rights, but can get money from you if a judgment exceeds a settlement they could have reached - - that's the so-called "hammer clause." Another factor to consider is the damage a settled or lost lawsuit can do to your reputation. With several states disclosing malpractice histories online, and the plantiff's bar hoping for the same disclosure from the National Practitioner Data Bank, avoiding a settlement on purely economic grounds may be in your best interest.

Free publication offered about genetics of Alzheimer's

A new fact sheet from the National Institute on Aging's Alzheimer's Disease Education and Referral Center summarizes knowledge about the genetics of Alzheimer's.

For a free copy of the *Alzheimer's Disease Genetics Fact Sheet* or other information about Alzheimer's, phone the ADEAR Center at 800-438-4380.

Researchers begin study of abnormal uterine bleeding

The Department of Obstetrics & Gynecology at the Robert C. Byrd Health Sciences Center, Charleston Division, will be one of 19 medical centers around the U.S. collecting data on women with dysfunctional uterine bleeding to compare the effectiveness and subsequent quality of life for patients who undergo surgical treatments - - hysterectomy or endometrial ablation - - to stop excessive menstrual bleeding.

The University of Maryland School of Medicine received a $6.6 million grant from the Agency for Health Care Policy and Research for the five-year study. The medical centers are recruiting 800 women who elect to undergo surgical treatment and 500 women who at least initially do not have a surgical procedure.

Dr. Tamer Yalcinkaya, associate professor of the Department of Obstetrics & Gynecology at the Charleston Division of the Robert C. Byrd HSC, is the clinical director for this study. Physicians who want to refer their patients for possible participation in this study can contact Dr. Yalcinkaya or clinical coordinator, Kelly Gilbert, R.N., at (304) 342-0816.

WVU Ophthalmology conference scheduled

The Department of Ophthalmology at the West Virginia University School of Medicine will sponsor the 19th Annual Clinical Ophthalmology Conference, October 9 and 10, at Lakeview Resort and Conference Center in Morgantown.

Lasker Award-winning Al Sommer, M.D., M.H.S., known for his work on the public health aspects of blindness prevention and child survival will be a featured speaker. Drs. James Rowsey, Mark Mannis and Ted Werblin, will speak on refractive surgery. For more information, phone (304) 293-3757.

The West Virginia State Medical Association

131st Annual Meeting

August 26-29, 1998

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- Entertainment
- Tournaments
- Exhibits
- Receptions
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Registration Form

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Phone _____ **Fax** _____

Specialty _____

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Would you like to register over the phone? Just call us at (304) 925-0342. Please have your Visa or MasterCard ready.

Fax us your application! (304) 925-0345.

Request an e-mail registration form! Visit our website at www.wvsma.com. Complete our Guestbook and request a registration form!

Cancellation of registration should be in writing. If a cancellation is postmarked or phoned to the WVSMA before August 1, 1998, the paid registration fee will be refunded less a $50 administrative charge. For written or phoned cancellations after August 1, 1998, no refunds will be made.

Early Bird Registration Fees — Before August 1, 1998

☐ WVSMA Member	$115
☐ Non-member	$165

Registration Fees — After August 1, 1998

☐ WVSMA Member	$125
☐ Non-member	$175

Lunch & Learn —
Thursday, August 27, 1998 — *"Appropriate Scope of Practice"*

☐ WVSMA Member	$50 (each session)
☐ All others	$35 (each session)

Lunch & Learn —
Thursday, August 27, 1998 — *"Computers in Medicine"*

☐ WVSMA Member	$50 (each session)
☐ All others	$35 (each session)

Total Due: _____

Payment by: ☐ Check ☐ MasterCard ☐ VISA

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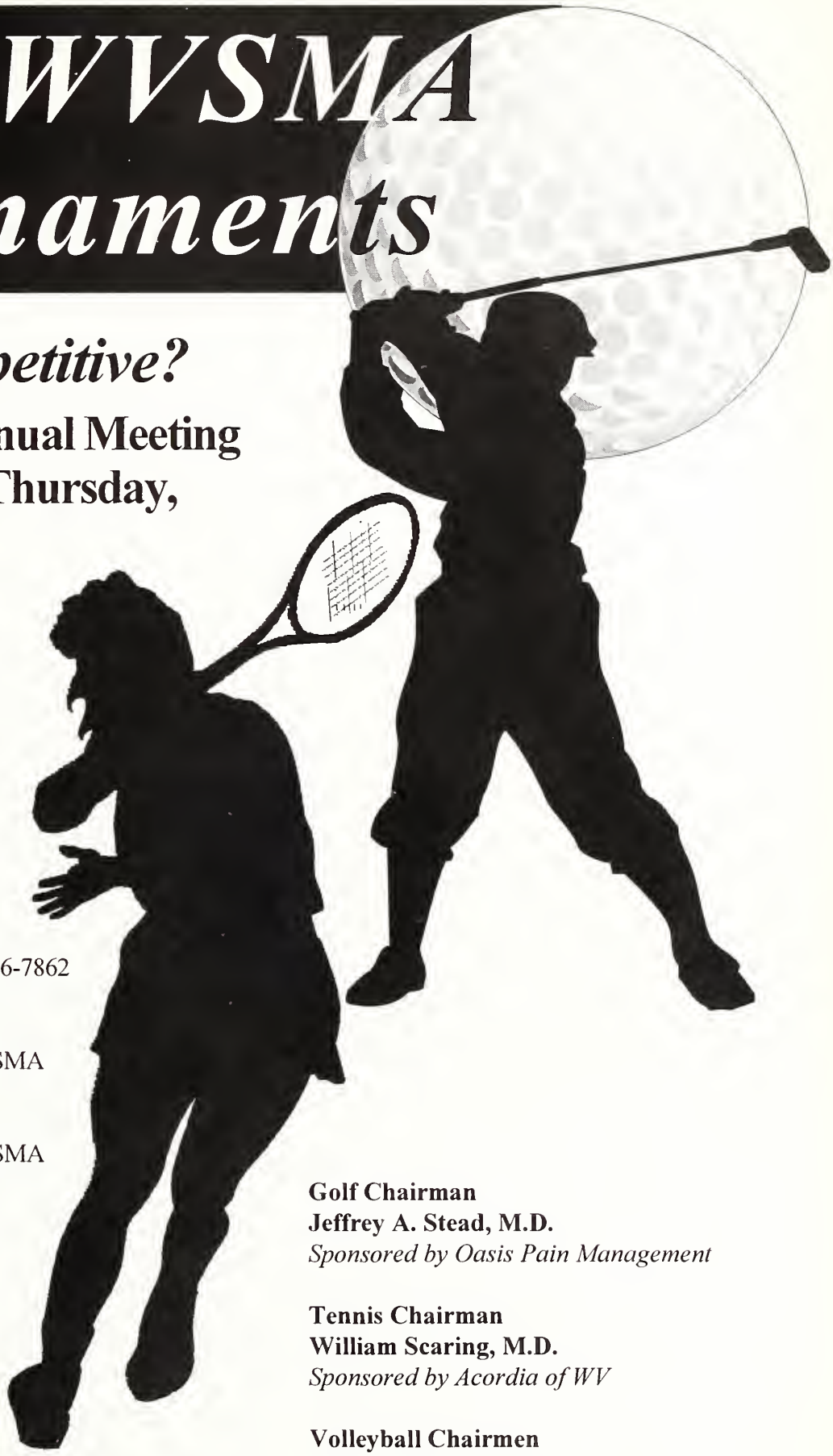
Signature _____

1998 WVSMA Tournaments



Feeling Competitive?

Join us for the Annual Meeting Tournaments on Thursday, August 27!

To Register for:

- **Golf** Please call (304) 536-7862 for tee times.
- **Tennis** Sign up at the WVSMA Registration Desk
- **Volleyball** Sign up at the WVSMA Registration Desk

Golf Chairman
Jeffrey A. Stead, M.D.
Sponsored by Oasis Pain Management

Tennis Chairman
William Scaring, M.D.
Sponsored by Acordia of WV

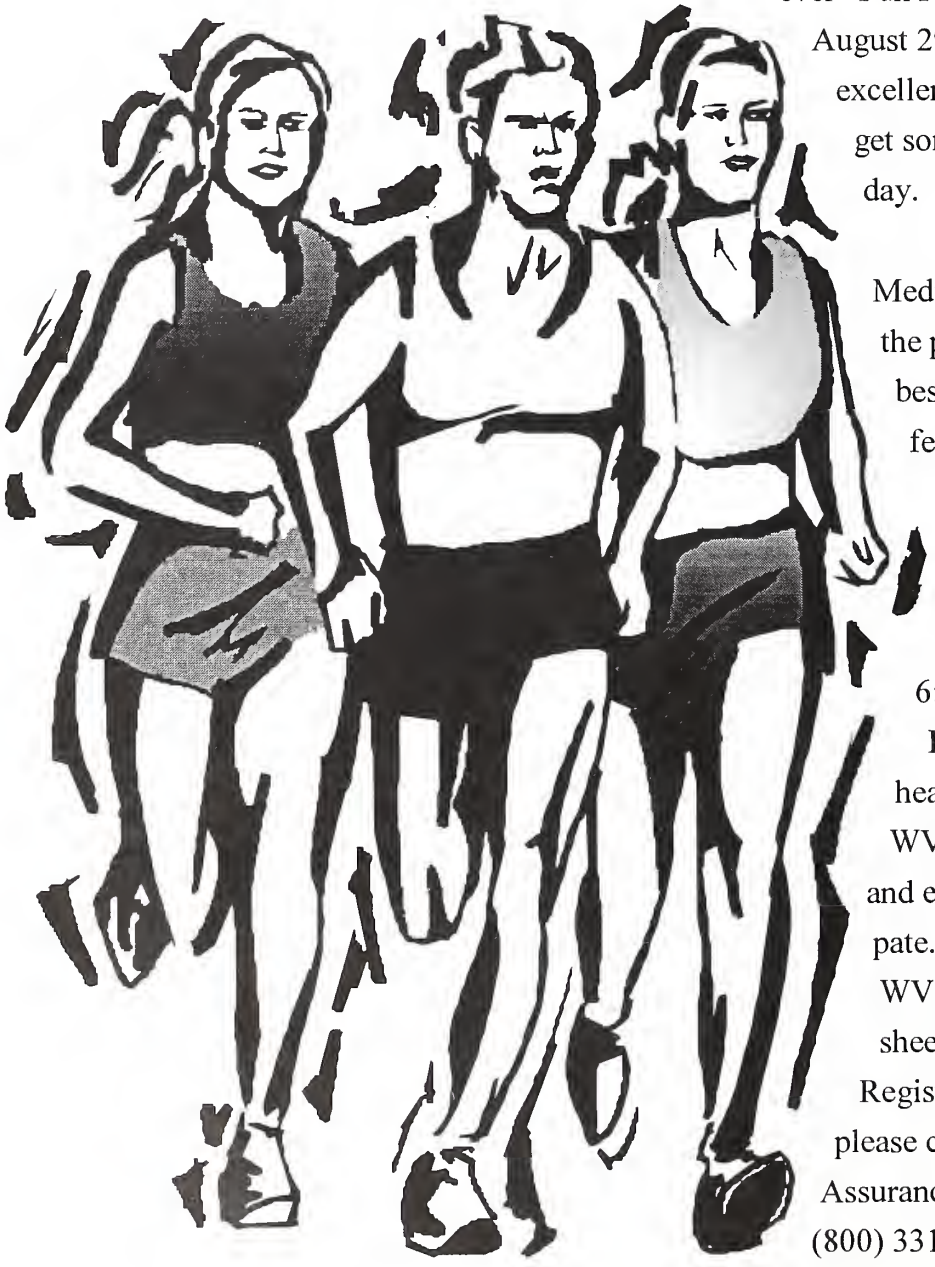
Volleyball Chairmen
Ron D. Stollings, M.D.
James L. Comerci, M.D.
Sponsored by Novartis Pharmaceuticals

For more information, please call Christina at the WVSMA, (304) 925-0342.

Join us at The Greenbrier
Saturday, August 29 at 7 a.m. for a

"Fun Run-Walk"

Hosted by Medical Assurance of West Virginia



As part of the West Virginia State Medical Association's 131st Annual Meeting at The Greenbrier, August 26-29, Medical Assurance is hosting its first ever "Fun Run-Walk" Saturday, August 29 at 7 a.m. The 2-mile run/walk is an excellent way to work off some calories and get some exercise before you start your day.

Medical Assurance will provide hats to all the participants and will offer prizes for best dressed, best "hat hair," fastest female, fastest male, best dressed, oldest participants and other flattering categories! Fruit, granola bars, coffee, fruit juices and water will be served starting at 6:30 a.m.

Plan now to attend this fun and healthy event at The Greenbrier. All WVSMA members, spouses, children, and exhibitors are encouraged to participate. Look for more information in the WVSMA Preliminary Program. Sign up sheets will be located at the WVSMA Registration Desk. For more information, please call Kathi Burton at Medical Assurance, (304) 522-0601 or (800) 331-6298, fax (304) 522-0602

The West Virginia State Medical Association presents

DiSalvo & We Three

Join us for a wonderful, relaxing evening of music at The Greenbrier, Friday, August 28 from 9 p.m. to Midnight.

DiSalvo & WE THREE promises to mesmerize the crowd with their variety of music, with styles ranging from Classical Jazz, to the Swing Era of the 50s, to Italian Folk and popular music of the 90s.

This five member band, formed in 1965, is well-known around the country, having just recorded their fifth album.

Plan to attend this exciting evening of music and dancing. The band will begin at 9 p.m. in the Chesapeake Hall immediately following dinner in the main dining room. Although there will be no cost for the event, donations will be accepted for the AMA-Education and Research Foundation.

CME & Special Events

Camcare Health Education & Research Institute

"Issues in Medical Ethics"
June 17, 8 a.m. - 5 p.m., Days Inn Conference Center, Flatwoods

Four Two-Hour Sessions
Sept. 22; Oct. 6; Oct. 27; and Nov. 3; 5 p.m. - 7 p.m.; Camcare Health Education & Research Institute's Education and Training Center, Charleston

"Trauma in Pregnancy"
(Teleconference) June 18, Therese Whitt, M.D., F.A.C.E.P., noon - 1 p.m.

"New Medicare Laboratory Regulations"
June 24, David Anderson, M.D., Twin Falls Resort State Park, Mullens, 6 p.m.

"Breast Cancer Prevention Study"
July 8, Steven Jubelirer, M.D., Green Hills Country Club, Ripley, 6 p.m.,

"Appropriate Documentation"
July 9, Stan Breaux, Plateau Medical Center, Oak Hill, 6 p.m.

"Telemedicine in West Virginia"
July 10, Joseph T. Skaggs, M.D., and Barbara McKee, RN, Logan General Hospital, Logan, noon

"Blunt Trauma"
July 15, James Kessel, M.D., Man ARH, Man, 6 p.m.

"Pediatric Advanced Life Support Provider Course"
August 13-14, 8 a.m. - 4:15 p.m., Camcare Health Education & Research Institute's Education and Training Center, Charleston

"Advanced Cardiac Life Support Provider Course"
Aug. 15-16 & Sept. 10-11, Robert C. Byrd HSC of WVU, Charleston, 8 a.m. - 4:30 p.m.

Huntington Medical Community Foundation

"Credentialing and Peer Reviews"
June 17, Hoyt Burdick, M.D., and Paul English Smith, J.D., Williamson Memorial Hospital, Williamson, noon luncheon

"Plastic/Wound Management"
June 22, Adel P. Faltaous, M.D., Tug Valley Medical Society Meeting, Starters Restaurant, Williamson, 6 p.m.

"Cases in Sports Injuries/Imaging"
June 25, Rabah Boukhemis, M.D., Pleasant Valley Hospital, Point Pleasant, noon luncheon & lecture

"New Therapies and Diagnostic Procedures in Malignant Melanoma"
Aug. 18, Frank Renshaw, D.O., Williamson Appalachian Regional Hospital, South Williamson, Ky., 6 p.m.

"ALL: The Most Common Malignancy of Childhood"
Aug. 24, Andrew Pendleton, M.D., Three Rivers Medical Center, Louisa, Ky., 6 p.m.

"New Concepts in Parkinson's Disease"
Aug. 25, Carl F. McComas, M.D., Paul B. Hall Regional Medical Center, Paintsville

Marshall University School of Medicine

"Barrett's Esophagus"
June 23, Gary Faulk, M.D., Cabell Huntington Hosp. 8 a.m.

"Osteoarthritis"
Aug. 27, Wayne Riskin, M.D., Cabell Huntington Hosp., 1 p.m.

Robert C. Byrd HSC - Morgantown

"Tamoxifin and the Gynecologist"
June 17, Mark Gibson, M.D., Fairmont Clinic, Fairmont, 1 p.m.

"Evaluation of Neck Masses in Children"
July 7, Hassan Ramadan, M.D., Fairmont General Hospital, Fairmont, 7:30 p.m.

"Update on AIDS/HIV"
July 9, Wesley Farr, M.D., Wetzel County Hospital, New Martinsville, 7 p.m.

"Irritable Bowel Syndrome"
July 15, Lisa Gangarosa, M.D., Fairmont Clinic, Fairmont, 1 p.m. - 2:30 p.m.

West Virginia State Medical Association

"WVSMA's Annual Meeting"
Aug. 26 - 29, The Greenbrier, White Sulphur Springs

Post

On a table laid of stainless steel,
in a room bounded by enameled tile,
yields hesitantly a prior life
to a probe, a mind - - an answer to be.
The physician, dissecting sees,
likens with microscopic eye
to a glow in darkness - - neon backlit signs:
Vesalius, Virchow, Rokitansky.
No more exercises of a life left,
ingesting, digesting, expelling,
their sanctuary now breached by a hook,
each particle sifted through science's net,
every shade, nuance, history's meaning
breathes existence into a new-found book.

Bureau for Public Health News

This page of material is submitted and paid for by the Bureau for Public Health.

WIC builds support for breastfeeding

"You might be a breastfeeding mother if . . . both you and your baby end each meal with a satisfied smile on your face."

The staff of the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) believes that offering accurate information in clinics, sharing experiences about breastfeeding, and repeating positive messages is an effective way of providing a supportive environment for women considering breastfeeding and for mothers already nursing. In addition, the staff stresses the use of breastfeeding peer counselors -- mothers helping mothers, to help accomplish breastfeeding goals.

Breastfeeding peer counselors in clinics help reassure women about their ability to breastfeed by providing needed information and sharing practical experience. These women are now available in all 55 West Virginia counties . . . repeating the messages and offering support and timely guidance over and over again.

Support for the decision to breastfeed, as Best Start Social Marketing has shown, is an overpowering key to women initiating and continuing to breastfeed. This support is shown in various forms both within WIC clinics and, increasingly, out in communities throughout the state. Now, the program's challenge is to maintain or improve the level of support for breastfeeding within the WIC programs, while helping to build the support of others in the community -- family, neighbors, medical providers and employers.

The slogan, *"Loving Support Makes Breastfeeding Work"* has been promoted throughout West Virginia since August 1997. As a pilot state for researching and implementing the WIC National Breastfeeding Promotion Campaign, the program has given great priority to building support for breastfeeding families.

Dialogues with women in the WIC clinics have revealed that hospital practices and the support of physicians play pivotal roles in a woman's confidence and success with breastfeeding. In order to reach the medical community, WV WIC is co-sponsoring for the first time a CME conference with the departments of OB/GYN, Pediatrics and Family Practice at the West Virginia University School of Medicine entitled *"Breastfeeding Management for Medical Practitioners."* This conference will take place on October 10 and will be piggybacked with the WV American Academy of Pediatrics' annual meeting to increase physician participation.

To further involve the medical community in breastfeeding support, WIC publishes the newsletter *WV Breastfeeding Updates.* To receive a copy of this newsletter, contact Connie Neuner at (304) 558-0030.

Changes slated for Medical Waste Rule

The WV Infectious Medical Waste Program recently completed a series of meetings designed to overhaul the Infectious Medical Waste rule. This revision was prompted by a December 1996 decision of the WV Supreme Court of Appeals.

In that decision, the court found the current rule lacked provisions for incorporating public participation in the permit process for non-commercial infectious medical waste facilities, as required by the Medical Waste Act (§20-5J et seq.) In addition, a bill which passed the 1997 legislative session (SB 409) necessitated changes in the current permit process for the siting of commercial infectious medical waste facilities. SB 409 created §20-5K which provides for a public referendum in the county in which a commercial infectious medical waste facility is proposed to be sited. This referendum may be called for by the county commission or by a petition of registered voters.

A committee, which included concerned citizens, physicians, Bureau staff and representatives from hospitals and environmental groups, helped draft the necessary changes to the rule. Also, a near final draft of the rule changes has been reviewed by individuals representing haulers and potential developers of commercial infectious medical waste treatment facilities.

Lead Abatement Act passed by Legislature

The WV Lead Abatement Act (HB 4034) was passed by the Legislature on March 14, and will become effective 90 days from passage. The new legislation will be administered by the Bureau, which plans to emergency file rules upon the effective date of the bill.

In 1992, Congress passed the Residential Lead-Based Paint Hazard Reduction Act. This rule established training and certification requirements for lead abatement professionals and required states to establish licensure programs by August 31, 1998. Until that time, the Bureau will prepare and submit an application for approval of the states' lead abatement licensure program to the EPA.

The most common source of lead exposure is lead-based paint hazards. Studies indicate that 1.7 million, or one out of 11 children have blood-lead levels above safe limits.

Mid-Winter Clinical Conference

Embassy Suites, Charleston, W.Va.

January 21 - 24, 1999

WVSMA is announcing its FIRST Mid-Winter Clinical Conference at the NEW EMBASSY SUITES!

Make plans NOW to attend!

WVSMA

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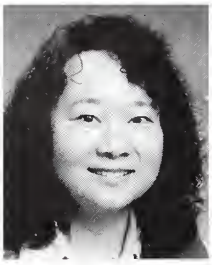
Robert C. Byrd Health Sciences Center of West Virginia University News

Cancer researchers awarded patent

Pathak



Wei-Shau Hu

Genes that kill cancer but don't harm healthy cells: it seems like a lot to hope for. Thanks to two researchers at the Mary Babb Randolph Cancer Center, science is one step closer to finding a safe way to deliver these "killer genes" and winning the war against cancer.

Vinay Pathak, Ph.D., and Wei-Shau Hu, Ph.D., have were awarded a patent for their invention of the E-minus retroviral vector -- a novel method of delivering genes designed to fight and kill cancer cells.

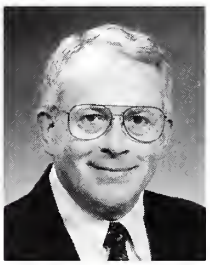
Researchers in biotechnology worry that biotech medicines that have been engineered to kill off disease could reproduce in the body and infect healthy cells. Drs. Pathak and Hu developed a retrovirus that specifically targets cancer cells, while at the same time, it destroys its own capacity to reproduce. This eliminates the chance that any healthy cells would be affected.

Dr. Batholomew joins OB/GYN scholars

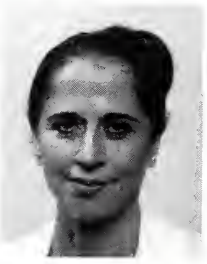
Dr. Deborah Ann Bartholomew has been named to the first class of the Educational Scholars Development Program, sponsored by the Association of Professors of Gynecology and Obstetrics and Solvay Pharmaceuticals.

Dr. Bartholomew is one of 20 physicians across the U.S. to be selected. The 15-month program focuses on curriculum and instruction; measurement and evaluation; research and statistics; leadership and management.

Bodensteiner, Khakoo earn leadership posts



Bodensteiner



Khakoo

Dr. John Bodensteiner, pediatrics/neurology, was recently elected president of the Southern Pediatric Neurology Society. Dr. Bodensteiner also is serving as president-elect of the Professors of Child Neurology, the national organization of academic child neurologists.

Dr. Rashida Khakoo, infectious diseases, has been elected governor-elect of the West Virginia Chapter of the American College of Physicians. Her term as governor-elect began in April and her four-year term as governor will begin in April 1999.

Dr. Meyer named "Rising Star" by ACPM

Dr. John D. Meyer, director of the residency program in occupational medicine, has been named the 1998 "Rising Star" by the American College of Preventive Medicine.

Dr. Meyer was chosen for the honor from among 2,000 physician members of the College.

Science fair involves junior high students from 17 counties

Hundreds of junior high students from 17 counties in West Virginia participated in the fourth Health Sciences and Technology Academy (HSTA) science fair on May 2 at Capital High School in Charleston.

"We had 400 students presenting more than 100 different projects," says Ann Chester, Ph.D., HSTA project director and assistant vice president for health sciences center of social justice at WVU. "A number of them did computer-assisted presentations."

The HSTA project involves university level scientists with junior high students and teachers, and with community volunteers, including physicians. It is intended to encourage young people from rural or disadvantaged areas, and those from and racial and ethnic minorities, to follow their talents into careers in science and health.

Graduating class honors Dr. Schiebel

The graduating class of the WVU School of Medicine has chosen Dr. Franklin G. Schiebel as "Clinician of the Year."

Medical school seniors vote each year to select one faculty member who is active in teaching them the skills of patient care and who they wish to honor as their role model. Dr. Schiebel, an associate professor of surgery, has been a WVU faculty member since 1988. He accepted the award from Phillip Aguila, president of the Morgantown Campus senior class, and Dr. Robert D'Alessandri, dean of medicine and vice president for health sciences.

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From the Medical Director . . .

At MAMSI we know that physician involvement and leadership are essential if patients are to remain well-served as our health care system evolves.

We invite you to join with us if you haven't already. We need you to help make health care truly work in West Virginia - for your patients, and for you.

Fred Holt

Fred F. Holt, M.D., J.D.
Medical Director for West Virginia

We welcome the physicians of the West Virginia Primary Care Association to our network!

Charleston - 343-2692 Morgantown - 285-2900 Wheeling - 242-7766 (800) 469-8474

Marshall University School of Medicine News

Governor tours new MU School of Medicine complex at Cabell

Hospital president Don Smith; Delegate Margarette Leach; Dr. Charles McKown, dean of the MU School of Medicine; Delegate Arley Johnson; and Governor Cecil Underwood discuss the Health Science Library. One of the nation's most sophisticated in its information access, the library will be open to the public.

With construction nearly complete, Governor Cecil Underwood toured the new Marshall University School of Medicine complex, which is scheduled to open in June.

Accompanied by Delegates Arley Johnson and Margarette Leach, the governor toured both the six-story University Physicians Center and the four-story Center for Rural Health.

"I'm impressed not just with the beauty of the facility but with the utility of the facility" for treating patients, teaching students and conducting rural health research, Underwood told reporters. "This is state of the art, and I think it will be a focal point for growth in biomedical technology and all technology," he said, adding that it also will be a "powerful magnet for attracting growth in the private sector."

The center, constructed in partnership with Cabell Huntington Hospital, will handle more than 175,000 patient visits annually to the school's 120 faculty physicians, said James Schneider, project director and associate dean.

Referring physicians who have questions about moving dates can get information by calling Marshall's referral system, Specialists on Call, at 800-342-7288.

Medical students, faculty honored

More than a dozen students and physicians received end-of-year awards at the School of Medicine.

Dr. Randall Hawkins of Point Pleasant was named rural clinical preceptor of the year. A 1987 graduate of Marshall's School of Medicine, he has served since 1994 as a teacher for third-year medical students who are doing rural rotations.

"Dr. Hawkins is much in demand with students," said Dr. Patrick I. Brown, noting that the work of Hawkins and rural physicians like him is critical to the success of the statewide Rural Health Education Partnership program.

Keri K. Hall of Elkview received the Bertha and Lake Polan Award as the graduate with the highest academic standing, and the Janet M. Glasgow Memorial Award.

Other award winners were: **Joshua A. Haddox**, MUSOM Alumni Association Recognition Award; **Janelle Thomas**, the Ciba-Geigy Award, the Excellence in Emergency Medicine Award and a Janet M. Glasgow Achievement Citation; **Sarah Bolen Curtis**, the W. Edwin Black Award for rural health; **Richard Booth**, the Lloyd F. Zacharias Award for OB/GYN; **Mary Faw**, the Thomas G. Folsom Award for pediatrics, and **Mary Rose Boehm**, a Janet M. Glasgow Achievement Citation.

Also recognized were: **Mary Jo Martin** for receiving the Community Project of the Year Award from the Eastern WV Rural Health Education Partnership Consortium; **Dr. P. Mitchell Charles** as the attending physician of the year; **Dr. Todd Myers** as resident of the year; and the **Dept. of Emergency Medicine** at Cabell Huntington Hospital as outstanding clinical department.

Research Day awards presented

More than 60 projects were presented at the 1998 Research Day, which featured a keynote address from cancer researcher Jerome Brody, M.D., of Boston University School of Medicine.

Lester R. Bryant Awards went to: **Melody Cyrus**; **Dan G. Lister**; and **Ishmael W. Stevens Jr.**; the Thelma V. Owen Award went to **Todd R. Myers;** the Roland H. Burns Awards went to **Frank E. Fumich** and **Sangeeta R. Patil**; the Anagene B. Heiner Award went to **Angela Ridgel**.

Tanya Warwick, a second-year med student, received a $3,000 student research award from Alpha Omega Alpha. The new inductees to Alpha Omega Alpha were students **Adam Franks**, **T. Eugene Justice** and **Bryan Springer**, and **Drs. Thomas Rushton**, **Joseph Evans** and **Kim Jordan**.

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West Virginia School of Osteopathic Medicine News

Work to begin on new library facility, lab

The West Virginia School of Osteopathic Medicine is one step closer to having a new library, bookstore and laboratory with renovation set to begin this spring on the former Greenbrier Community College Center facility on the campus of WVSOM, according to President Olen E. Jones Jr., Ph.D.

"We have awarded the bid to the contractor and the contract has been signed," said Dr. Jones. "Renovation will begin in early May on the $2 million project," he added.

Work will include renovation of the existing structure to include a new high-tech library and bookstore, a new Osteopathic Principles and Practice laboratory, as well as additional student study space. A new breezeway will also be built to attach the free-standing facility to the main WVSOM school building.

Dr. Herr selected as Practitioner of the Year

Herr

Paul W. Herr, D.O., F.A.C.O.F.P., has been named the 1998 West Virginia "Practitioner of the Year" by the West Virginia Society of Osteopathic Medicine, Inc.

Dr. Herr, professor of family medicine at WVSOM, was presented the honor in Morgantown on April 25 at the state society's annual convention. Dr. Herr was also selected to present the prestigious Mountaineer Address at the convention.

Dr. Herr was been a member of the WVSOM faculty since 1985, and has served as medical examiner for Greenbrier County for 13 years.

Dr. Hunt elected leader of osteopathic society

Hunt

Howard Hunt, D.O., F.A.C.O.F.P., associate dean for clinical education and professor of family practice, was recently elected president of the West Virginia Society of Osteopathic Medicine, Inc.

Before coming to WVSOM, Dr. Hunt taught at the Chicago College of Osteopathic and Kirksville College of Osteopathic Medicine. He also has served as president of both the Arizona Osteopathic Medical Association and the Missouri Association of Osteopathic Physicians and Surgeons.

Student lobbying group travels to D.C.

Six WVSOM students were part of a group of 50 osteopathic med students who recently visited Capitol Hill to lobby for student concerns with representatives and senators from New York, New Jersey, Pennsylvania and West Virginia.

The student lobbying group represented four of the nation's 19 osteopathic medical schools, including 21 students from the NY College of Osteopathic Medicine - NY Institute of Technology, 15 students from the University of Medicine and Dentistry of NJ - School of Osteopathic Medicine, and the six WVSOM students.

Web page now online

WVSOM has launched its new web site, and Internet users can now access a variety of material including information about admissions, financial aid, school publications, and links to osteopathic organizations.

The site is http://www.wvsom.edu.

Dr. Blue appointed to new biology position

Blue

William Blue, Ph.D., associate professor of microbiology, has been appointed chairman of the Division of Structural Biology at the West Virginia School of Osteopathic Medicine, announced James Stookey, D.O., vice president for academic affairs.

In his new position, Dr. Blue will oversee the Division of Structural Biology, which includes the disciplines of microbiology and anatomy. He will continue to teach microbiology at WVSOM in addition to his new responsibilities.

Memorial service held for human gift donors

Faculty, staff and students from WVSOM gathered April 9 at Rosewood Cemetery recently to pay respects to those who have donated their bodies to medical science.

Family members of the deceased were thanked by anatomy professors and first-year students who furthered their medical education due to the generosity of human gift donors.

"On behalf of everyone at WVSOM, I would like to thank the families for the generous gift their loved ones gave by donating their bodies to medical science. That gift will carry on with these students and remain with them throughout their professional lives," said Bill Martin, Ph.D., professor of anatomy.

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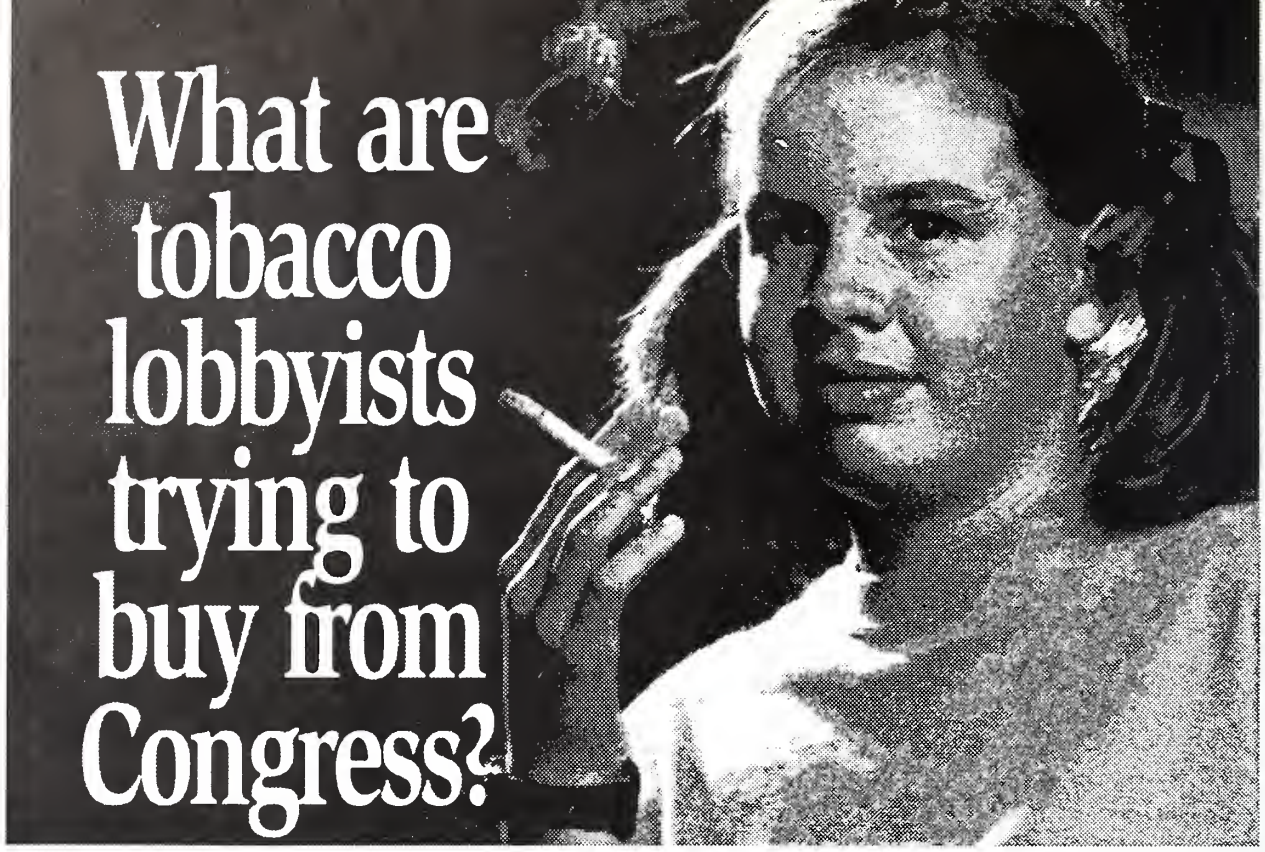

After decades of lying about addiction and disease, tobacco companies have launched a last-ditch scheme to continue marketing to kids: flood Congress with cash.

During the first half of 1995, tobacco industry contributions to political parties skyrocketed more than 400 percent. Tobacco companies gave more than $1.6 million ($1.5 million to Republicans), becoming the GOP's largest donor by far.

Why the sudden surge? President Clinton and Members of Congress from both parties are backing new limits on tobacco marketing to kids—limits that could save thousands of children from addiction, disease and death. Tobacco companies are desperately trying to buy opposition.

Voters want Congress to say no to the tobacco industry. More than 85 percent say Congress should support the administration's effort to protect children.

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AMA-ERF

AMA-MSS Section V meeting a success

This has been a very busy time of year, both for medical students and the WVSMA's Medical Student Section. In addition to the many academic endeavors we have been involved in, I am pleased to report that all our efforts in planning the AMA-MSS Section V Conference finally came to fruition and more than 60 students from West Virginia, Ohio, Michigan, Indiana and Kentucky attended the meeting in Morgantown, March 27-29.

Senator Jay Rockefeller spoke on *"The Prognosis for Healthcare in America"* for the opening session on Friday evening, which was followed by a panel discussion with Dr. Robert M. D'Alessandri, dean of the WVU School of Medicine and vice-president for health sciences; Dr. Ted Lewers, a trustee for the AMA; and Kristin Cooper, the AMA-MSS governing council chair. In addition, WVSMA President Dr. Thomas Chang also addressed the audience that evening. The next day, a very interesting program was presented by Dr. Stephen Permison, deputy director of the Division of Quality Assurance at the National Practitioner Database, regarding the database and its parameters. Fred Holt, M.D., J.D., medical director of the West Virginia and North Carolina offices of Mid Atlantic Medical Services, Inc., instructed us on the legal intricacies of medical practice. In the afternoon, Skip Santori, MBA, of Santori and Peters, explained how to plan our personal and business finances. Following the educational sessions, the sectional business meeting was held to discuss upcoming resolutions at the AMA-MSS Annual Meeting and to hear the platforms of all sectional candidates for national office. The meeting concluded on Sunday after several people arose to the challenge of a white water raft trip down the chilly waters of the Cheat River.

Everyone who attended the conference commented on the quality of the program. We received very positive feedback both on the format and educational content of the meeting. Also, many people were pleasantly surprised with the facilities and entertainment found in Morgantown. I would like to take this opportunity to thank everyone involved with organizing the meeting; especially Donna Webb, for without her patience and know-how, success would have been impossible.

In April, new officers were elected for the WVSMA-MSS and I began my role as president. The other officers who will be serving until next year will be: Ken McDowell, MSII WVSOM as vice-president; and Michael Beasley, MSI WVU, as secretary-treasurer. We are honored for the privilege to serve you. Also, we hope to continue the success achieved by the outgoing officers.

If there is anything we can do for you as students, friends or officers please feel free to contact us.

Stephen Greer, MSII
President, WVSMA-MSS

Obituaries

Jerry Edens, M.D.

Dr. Jerry Edens, 55, died at his home in Poca on Saturday, April 25, after suffering a massive heart attack. He had been helping his family members take care of his mother, Mildred Evans, 74, who had been battling cancer for a long time and had slipped into a coma at Charleston Area Medical Center, Memorial Division. She died just a little more than an hour after Dr. Edens.

At the HealthPlus Urgent Care in St. Albans where Dr. Edens worked, his patients were known at "Jerry's Groupies," said Sally Llewellyn, vice president for medicine services at CAMC. "They'd call to make sure he was working that shift. Whatever it was, it could wait until the next day when he was there," she added.

After Dr. Edens had heart bypass surgery two years ago he became even more dedicated to serving his patients, Llewellyn said, especially in being proactive about diagnosing heart problems.

Dr. William Harris described him as a good friend and hard worker.

"He was a quiet, unassuming individual," Dr. Harris said. "I admired his ability as a physician and his dedication to his patients and profession. He handled life's adversities with great dignity."

Dr. Edens received his M.D. degree from the West Virginia University School of Medicine in 1976 and completed his residency at the Kanawha Valley Family Practice Center. He studied addiction medicine at CAMC.

During his career, Dr. Edens was on the associate staff of Charleston Area Medical Center, was chief of CAMC's Department of Family Practice in 1984 and 1985, and was chief the Department of General Medicine at St. Francis Hospital in Charleston. In addition to his work at the HealthPlus Urgent Care in St. Albans, Dr. Edens was a volunteer physician to Health Right Clinic.

In addition to being a member of the WVSMA, Dr. Edens was a member of the American and West Virginia Academies of Family Practice, the AMA, Kanawha Medical Society, the American Society of Addiction Medicine and Southern Medical Association.

Survivors include his wife, Juanita G. Edens; sons, Darrell W. Edens, James D. Arrowood and Jeffrey S. Arrowood at home; daughter Kelli E. Edens of North Carolina; brother, Steven, of Cross Lanes; sisters, Joyce A. Williams of Pinch, Susan H. Carper of Grantsville; and one grandson.

Patrick Theodore Latos

Patrick Theodore Latos, 18, of Wheeling, son of Dr. Derrick L. and Michele Hughes Latos of Wheeling, died at home on April 2.

Patrick was an employee at Greco's Restaurant, Wheeling, and was attending Xavier University in Cincinnati. He was a member of St. Michael Catholic Church in Wheeling.

Patrick was preceded in death by a sister, Erin Kathleen Latos, in 1976. In addition to his parents, Patrick is survived by a brother, Michael Roy, a student at Butler University, Indianapolis, Ind.; his maternal grandmother, Phyllis E. Hughes of Shinnston; his paternal grandparents, Theodore P. and Viola Lagod Latos of Windsor Heights; several aunts, uncles and cousins.

Memorial contributions may be made to Young Life in the Ohio Valley, Wheeling, or to St. Michael Catholic Church, or the charity of the donor's choice.

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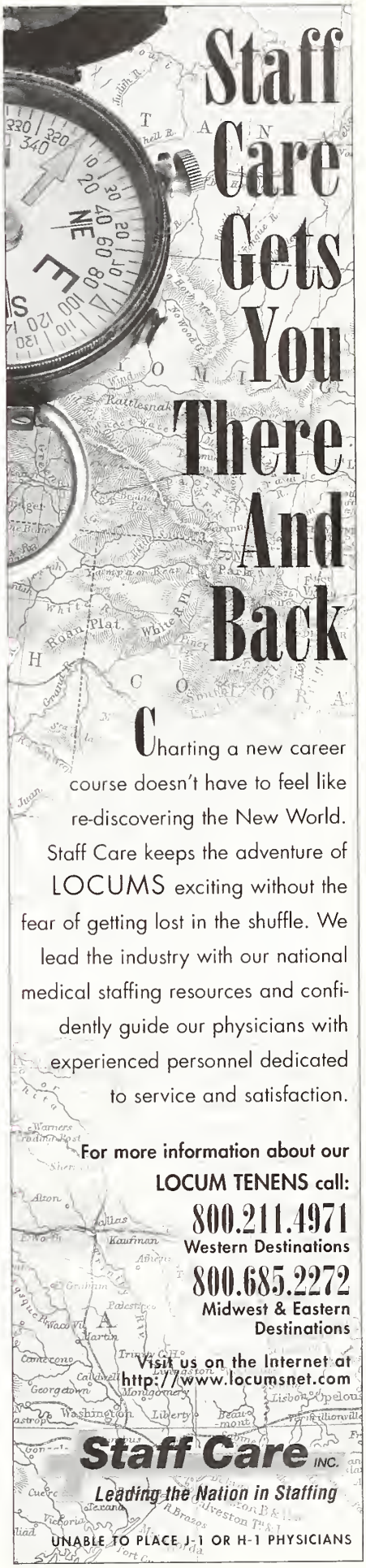

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Seminars:

Issues in Medical Ethics
One Day Program
Wednesday, June 17, 1998
8:00 a.m. to 5:00 p.m.
Days Inn Conference Center
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Four Two-Hour Sessions
September 22, 1998
October 6, 1998
October 27, 1998
November 3, 1998
5:00 p.m. to 7:00 p.m.
Camcare Health Education and Research Institute's Education and Training Center
Charleston, W.Va.

Pharmacology and Women's Health Issues: HRT/ Antidepressants/Contraceptives
August 12, 1998
4:00 p.m. to 6:30 p.m.
Robert C. Byrd Health Sciences Center of WVU
Charleston, W.Va.

Pediatric Advanced Life Support Provider Course
August 13-14, 1998
8:00 a.m. to 4:15 p.m.
Camcare Health Education and Research Institute's Education and Training Center
Charleston, W.Va.

Advanced Cardiac Life Support Provider Course
August 15-16, 1998
September 10-11, 1998
8:00 a.m. to 4:30 p.m.
Robert C. Byrd Health Sciences Center of WVU
Charleston, W.Va.

13th Annual Trauma Conference
September 18, 1998
8:00 a.m. to 3:30 p.m.
Tamarack
Beckley, WV

Pharmacology and Women's Health Issues: Outpatient Antibiotics, Pain Control/Weight Loss
October 14, 1998
4:00 p.m. to 6:30 p.m.
Robert C. Byrd Health Sciences Center of WVU
Charleston, W.Va.

2nd Annual Pediatric Critical Care Conference
October 8, 1998
8:00 a.m. to 3:00 p.m.
Robert C. Byrd Health Sciences Center of WVU
Charleston, W.Va.

Teleconference

Trauma in Pregnancy
June 18, 1998
Noon – 1 p.m.
Therese Whitt, MD, FACEP

On-Site Continuing Education Outreach Programs

New Medicare Laboratory Regulations
Twin Falls Resort State Park
Mullens, W.Va.
June 24, 1998
6:00 p.m.
David Anderson, MD

Breast Cancer Prevention Study
Jackson General Hospital
Green Hills Country Club
Ripley, W.Va.
July 8, 1998
6:00 p.m.
Steven Jubelirer, MD

Appropriate Documentation
Plateau Medical Center
Oak Hill, W.Va.
July 9, 1998
6:00 p.m.
Stan Breaux

Telemedicine in West Virginia
Logan General Hospital
Logan, W.Va.
Noon
Joseph T. Skaggs, MD
Barbara McKee, RN

Blunt Trauma
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Seminars:

Pediatric Advanced Life Support Provider Course
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August 29 – 30, 1998
Camcare Health Education and Research Institute
Charleston, W.Va.

Advanced Cardiac Life Support Provider Course
September 10-11, 1998
8:00 a.m. to 4:30 p.m.
Robert C. Byrd Health Sciences Center of West Virginia University/ Charleston Division
Charleston, W.Va.

Alternative Therapies
Friday, September 11, 1998
Tuesday, November 24, 1998
Camcare Health Education and Research Institute
Charleston, W.Va.

13th Annual Trauma Conference
Friday, September 18, 1998
8:00 a.m. to 3:30 p.m.
Tamarack, Beckley, W.Va.

Issues in Medical Ethics
(four 2-hour sessions)
September 22, 1998
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Robert C. Byrd Health Sciences Center of West Virginia University/ Charleston Division
Charleston, W.Va.

Pharmacology and Women's Health Issues: Outpatient Antibiotics/Pain Control/ Weight Loss
October 14, 1998
Robert C. Byrd Health Sciences Center of West Virginia University/ Charleston Division
Charleston, W.Va.

Eighth Annual Vascular Surgery Seminar
October 17, 1998
Robert C. Byrd Health Sciences Center of West Virginia University/ Charleston Division
Charleston, W.Va.

Cardiology Conference at Snowshoe
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On-Site Continuing Education Outreach Programs

Occupational Pneumococcosis
Man Appalachian Regional Hospital,
Man, W.Va.
August 18, 1998, 6:00 p.m.
Dominic Gaziano, MD

Update in General Surgery
Montgomery General Hospital
Montgomery, W.Va.
September 2, 1998, 12:30 p.m.
Robert Cochran, MD

Organ Procurement
Fayette County Medical Society
Plateau Medical Center
Oak Hill, W.Va.
September 2, 1998, 6:30 p.m.
Lawrence Wyner, MD

Food Borne Diseases
Logan General Hospital
Logan, W.Va.
September 11, 1998, Noon
Donald Rosenburg, MD

Current Issues in Cancer
Roane General Hospital
Spencer, W.Va.
September 15, 1998, 6:30 p.m.
James Frame, MD

Wound Care Management
Man Appalachian Regional Hospital,
Man, W.Va.
September 16, 1998, 6:00 p.m.
Scott Spradlin, DO

Update in Urology
Cafe Acropolis
Summersville, W.Va.
September 28, 1998, 6:00 p.m.
Joseph DeBord, MD

Overview of West Virginia Poison Control Center
Fayette County Medical Society
Montgomery General Hospital,
Montgomery, W.Va.
October 7, 1998, 6:30 p.m.
Elizabeth Scharman, PharmD

Managed Care and Your Practice
Man Appalachian Regional Hospital
Man, W.Va.
October 21, 1998, 6:00 p.m.
Glenn Crotty, MD

Camcare Health Education and Research Institute

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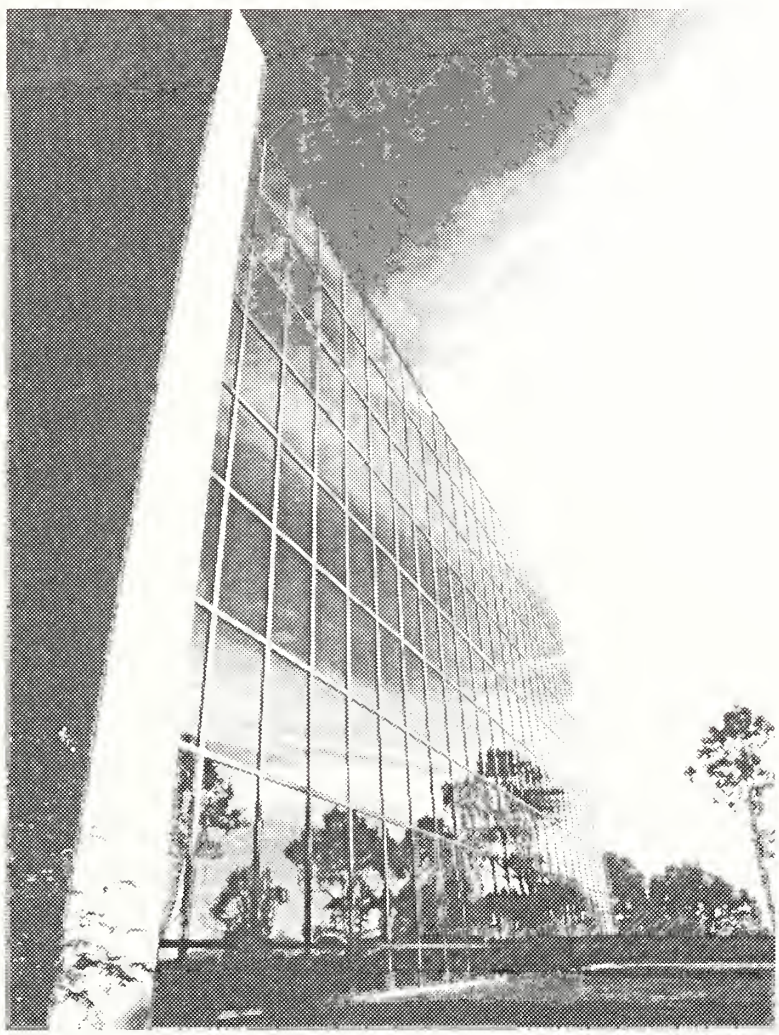

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Manuscript Guidelines

All scientific and special articles being submitted to the *West Virginia Medical Journal* must be created on an IBM compatible disc preferably in Wordperfect 6.1 or earlier versions. If the manuscript contains tables, the main body of the manuscript and references should be saved as one item, i.e., *article*, and then each table should also be saved as a separate item, i.e., *Table 1, Table 2.*

All scientific manuscripts should be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."* Papers will not be considered for publication if they have already been published or are described in a manuscript submitted or accepted for publication elsewhere. All persons designated as authors should have participated enough in the work to take public responsibility for the concept.

Manuscripts should be accompanied by one extra copy, be double-spaced, have each page numbered and should include a title page, an abstract of no more than 150 words, and references numbered consecutively. No more than 10 references will be published and then a statement will appear that the author should be contacted for the other references listed in the manuscript.

Tables, figures and photos should be numbered, and indicated with parentheses whenever they are mentioned in the text, i.e. (Table 1), (Figure 1). Legends should be included for all figures and photographs

Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author at a cost of $13 for each photo. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be created in black and white.

All scientific material is reviewed by the editor and three members of the Publication Committee. Depending on their content, other types of articles are usually only reviewed by the editor and should still be mailed to the same address. All articles should be addressed to: Stephen D. Ward, M.D., Editor, *West Virginia Medical Journal*, Charleston, WV 25364.

If you have questions or need more information, phone Nancy L. Hill, managing editor at (304) 925-0342.

Discerning a winning strategy

As my presidency draws to a close, I have taken time to reflect on the past year and also look toward our goals for the future. While I am quite proud of the accomplishments during my term and feel honored to have served, I have been working to leave the presidency of the West Virginia State Medical Association with a firm foundation for future action.

As part of your leadership team, we have diligently worked to better represent the interests of physicians and their patients in the legislative, judicial and administrative arenas. I think that it is fair to say that our visibility and clout have increased; our public perception has improved; and we have made important strides in management efficiency. With all that said, though, it is critical that we keep in touch with the pulse of the membership and the broader physician community so as to better represent their interests.

As part of that effort, I would like to commend Dr. Tom Spork, chairman of the Legislative Committee, for his recent survey which asked members to rate the importance of various legislative issues and express their opinions about our future legislative direction. Incredibly, we received over 500 responses, the highest return on any survey conducted by the WVSMA in recent years.

What did the results show? Not suprisingly, the top issue with our members was tort reform, with the provider tax coming in second. Given the choices, predicting the other priorities would not prove as easy. The results showed that ensuring Provider Service Organization fairness to physicians was a strong third with reform of

the West Virginia Guaranty Fund/ malpractice insurance solvency fourth. *(The complete results are being mailed to members.)*

Hence, the members have spoken. These results provide the foundation for our legislative strategy. Given the competing issues and limited resources, a mandate from the members is vital.

Our joining with the business community on tort reform broadens the scope of interest but limits our independent efforts in this area. If, in fact, this coalition does not aggressively pursue this cause, we will continue our efforts unilaterally.

I do believe that the repeal of the provider tax is imminent. Your continued activism has made a difference. The Governor's Tax Fairness Commission has once again reiterated its stance that the provider tax should be repealed and replaced with a "general excise tax" for which health care services would be exempt. However, we will have to remain vigilant in monitoring the progress of the commission as a new single business tax has been proposed with rates yet to be determined.

Likewise, I believe the WVSMA's tireless efforts to minimize the problems of managed care regarding patients' rights are bearing fruit. We were proud to lobby for the passage of Senate Bill 361, which creates a state patients' bill of rights. And, we are continuing our work with leading legislators on Health Maintenance Organization access standards (a particular problem in rural areas) and the future enactment of legislation to permit HMO participants to follow their treating physicians.

Recent indications also point toward progressive reform of the Board of Medicine. A recent study of the Board was conducted by the Federation of Medical Boards. Its analysis closely mirrors much of what our own members have been telling us. This can serve as an objective foundation on which to base future discussions with the Board, legislators and physicians.

As WVSMA members know, there are others in the health care arena with whom we have had serious differences. It is understood that we will have our share of both allies and enemies. However, it is my belief that only good can come from thorough and ongoing discussions with all involved, if nothing else but to better our respective positions. Whether we host these discussions or whether they occur in the halls of the Capitol, the nature of the political process dictates that debate, discussion, and occasional compromises will take place. We cannot afford to stick our heads in the proverbial sand. We must be key players in forging medicine's public policy.

With that in mind, I recently met with Mr. Bruce Carter, CEO of United Hospital Center in Clarksburg and a former board member of the West Virginia Hospital Association, to discuss some of the major issues affecting medicine. This meeting was exploratory in nature, but I would like to plan more such meetings with organizations such as the WVHA. Thus, it is my intent to hold a joint meeting between our executive committees to address a range of issues including: rate setting, Certificate of Need, provider service organizations, the provider tax, tort reform, HMO contracting and access problems, and patients' rights.

I do not suggest that we start wearing rose colored glasses. The external threats to organized medicine are real and formidable. Yet, it is my belief that the WVSMA is. philosophically grounded well enough to know when to pursue cooperative action; when to fight and when to compromise. It is my goal, as it is with your leadership team, to better discern a winning strategy in these truly incredible times.

As long as we constantly remind ourselves of the importance of our organization, the influence it wields, the responsibility that goes along with that influence, and our purpose - - to serve as advocates for both patients and our profession - - we will meet our overall goal of improving the health care in our state. There's still much to be done, but we're well on our way.

Thomas H. Chang, M.D.

Editorial

Political fence sitting

Both Democrats and Republicans want to sit on the fence. Neither can seem to get their legislative agenda right.

Happily, Republicans seem to be coalescing about approving an expansion of Medical Savings Accounts. But how much of an expansion? And what sort of success do they need demonstrated in the present version of MSAs to enable them to enthusiastically approve and endorse this only logical solution to the problem of reducing patient demand for care? Is there anyone not in agreement that this, not just unrestrained but overstimulated demand has been the springboard for soaring medical care expenses?

Democrats, of course, find MSAs anathema because it puts individual citizens, rather than a bureacracy loaded down with regulations, in charge of making decisions about the need for and extent of their own medical care. They remain convinced that government knows best what is good for us, its little children. On the other hand, Democrats have been espousing a new health proposal that, among other things, allows patients to sue HMOs and other managed care organizations over bad consequences stemming from care denied by these organizations.

To the extent such suits might thus hold blameless the attending physicians involved, this provision seems eminently commendable even if it is an unintended consequence of Democratic obeisance to plaintiff attorneys by providing them access to bigger game. Someone is going to get sued by any upstanding, dues-paying member of the plaintiff's bar any time he or she gets wind of an unhappy patient. When an attending physician's recommendations for care are disregarded by managed care aficionados, subsequent suits for damages should be directed at parties other than those attendings. Republicans, apparently out of fear of distressing or even bankrupting shaky health care organizations, oppose this.

To their merit, Republicans have also attempted to pass judicial reform measures limiting punitive damage awards as part of their product liability reform legislation. Their efforts in these endeavors have, of course, been frustrated by Democrats.

It seems to us that all the elements of good public policy on health care are being discussed in Congress. The problem is that horse trading with the various elements is going on for nothing more than strictly partisan political reasons, the November elections being imminent. There appears to be a danger that Republicans will swap their judicial reforms along with their MSA expansion in return for Democrats giving up patients' rights to sue managed care organizations. If this occurs, health care will have lost and nanny goverment will have triumphed.

One thing is certain, fence sitting and compromises will be made with results satisfactory to no one. In the meantime, demand for medical care under "free" or other tax subsidized forms will continue to escalate and the medical community including doctors, hospitals and the pharmaceutical industry will be blamed.

Stephen D. Ward, M.D.
Editor

Special AMA Delegation Report

The AMA House of Delegates reviewed over 800 pieces of business at the AMA Annual Meeting in Chicago from June 14-18. Some of the key issues that were debated at the meeting were:

1. **Collective bargaining.** There was an overall mood of aggressiveness in regard to the issue of collective bargaining. The House voted to direct the AMA, within the six weeks following the meeting to form a negotiation unit. The House also directed the AMA to work with the Federal Trade Commission and Department of Justice to change federal regulations that prohibit physicians from collectively bargaining. This represents a major change of direction for the AMA. From the passionate and intense testimony, it appears there is a nationwide demand in American medicine for this change.

2. **E & M guidelines.** There were 19 resolutions that the reference committee combined in a marathon two-day session. The final resolution calls for:
   a) Burden of proof for fraud in billing be placed on the Office of Inspector General.
   b) A "knowing and willful" standard for billing errors.
   c) Due process protection for physicians undergoing Medicare audits.
   d) Medical record confidentiality insurance.
   e) Discontinuance of prepayment audits.
   f) Simplified E & M documentation guidelines.
   g) Peer review for cases under question.
   h) Extension of the current moratorium on enforcement..

3. **Elections.** Dr. Thomas Reardon of Oregon won the election for the office of president-elect in a fairly-heated contest with Dr. Raymond Scalettar of Washington, D.C. Dr. Scalettar is a former trustee and gathered 40% of the vote. Doctors Susan Adelman of Michigan and William Plested of California won election to the Board of Trustees for the first time. Dr. Randolph Smoak of South Carolina won re-election to the Board.

In other business, this was the first AMA meeting that our delegation participated in a "caucus of the Virginias." Following an invitation last year from the Virginia delegation, our delegation joined physicians from our neighboring state to review House business prior to the opening session. This event was well-received and successful. We were asked to join the Virginia delegation for dinner on the final night of the meeting in order to meet each other on a more social basis, as well. It is anticipated that our respective delegations will continue this caucus.

The West Virginia delegation found itself shorthanded to cover all nine reference committees. Mike Fortunato, M.D., of Wheeling, attended the AMA meeting with his wife, Kathy, president of the WVSMA Alliance. Our delegation is very grateful to Dr. Fortunato for graciously covering a reference committee.

Our delegation submitted a resolution calling on the AMA to help curtail media violence. Dr. McAfee, past AMA president, spoke in favor of the resolution before the reference committee. He commended our delegation for this resolution and stressed its pertinence. The resolution passed without further debate.

On behalf of the West Virginia delegation present at the meeting — **Drs. John Holloway, Stephen Sebert, Stephan Thilen, Robert Hess, James Bryant, Dorian Williams, Joseph Selby, Ronald Cordell, Thomas Chang, Phillip Stevens and David Avery** — we respectfully submit this report.

Constantino Y. Amores, M.D., AMA Delegation Chairman
James D. Helsley, M.D., AMA Delegate

As physicians, our hearts have always been with our patients. Our mission, saving lives.

Once this was enough.

Today, however, we are called upon to save more than our patients' lives. We are called upon to save their rights as well.

That's why I'm asking you to support the American Medical Association (AMA) as well as your specialty society.

Together, we can achieve real and lasting changes. Already we have made great strides on behalf of our patients. Working together, we are stopping "gag" clauses, developing patient protection measures, and launching a wide spectrum of public health initiatives.

During Women In Medicine Month, we gratefully acknowledge the participation and support of all our female members. The AMA now has more women physicians than any other medical association. We encourage all female physicians, residents and medical students to become members. So please, join now. Your patients' future rights and your entire profession depend on your commitment today.

WOMEN IN MEDICINE MONTH
September Is

"Let's keep our commitment where our hearts are. With our patients."

Join the AMA and your specialty society.

For information about the new Women Physicians Congress, call 800 AMA-3211, ext. 4392.

Nancy Wilson Dickey, MD
President 1998-1999
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Special Article

S-O-S! When a malpractice insurer sinks, how do its doctors survive?

BERKELEY RICE
Senior Editor, Medical Economics Magazine, Montvale, N.J.

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Editor's Note: Medical Assurance of West Virginia, Inc., the endorsed malpractice carrier of the West Virginia State Medical Association, is given an A (Excellent) rating by A.M. Best, which is their highest rating for a medical malpractice insurance company, and given an A+ rating by Standard and Poor's.

Orthopedic surgeon Thomas Bender had just paid $27,500 for his malpractice coverage. Ob/Gyn Daryl Gildenblatt had just renewed his policy at a cost of more than $30,000. General surgeons Martin Popp and Patrick Brophy had continued their coverage for a total of nearly $50,000. The eight physicians of Obstetrics and Gynecology Associates had just signed up, paying nearly $300,000 in premiums and finance charges.

Unfortunately, most of that money is probably lost, because the company these physicians were dealing with — PIE Mutual Insurance Co. — is now out of business. The doctors, who practice in or near Cincinnati, are suing PIE's insurance agency, hoping to recover their losses. And they're only a few of the victims in what may be the worst medical-malpractice insurance disaster in history.

When Ohio officials declared PIE Mutual insolvent last December, the news sent shock waves throughout the medical communities of the Midwest. At its peak, the Cleveland-based liability carrier had insured more than 18,000 physicians, including about one-third of those practicing in Ohio. At the time of its demise, PIE was one of the country's biggest doctor-owned liability carriers, operating in Ohio, Indiana, Pennsylvania, Kentucky, Missouri, Kansas, Mississippi, West Virginia and Maryland.

As a result of PIE's collapse, nearly 15,000 physicians have not only lost millions of dollars in unrecovered premiums, they've also had to quickly purchase replacement coverage from other carriers, often at higher rates. And they've had to scramble to buy "prior acts" coverage for claims arising from their PIE-covered years.

The most vulnerable victims of this debacle are the doctors named in 4,250 outstanding claims filed while they were insured by PIE. With the company's demise, they are now at risk of losing their personal assets.

PIE in the sky?

Founded in 1975 by a group of Ohio physicians, PIE grew rapidly, due mostly to the appeal of its low premiums. Even when its published rates were comparable to those of competitors, they were often heavily discounted by aggressive sales agents. Another reason for the company's popularity among physicians was its exclusive retainer arrangement with the law firm of Jacobson, Maynard, Tuschman & Kalur, which had earned a reputation for its tough and successful efforts in defense of PIE-insured doctors.

PIE's success also may have been aided by its political generosity and adroitness. According to *The Columbus Dispatch*, PIE's president and CEO, Larry Rogers, contributed more than $330,000 to Ohio GOP campaigns between 1990 and 1997, and the company itself gave $470,000. In neighboring Kentucky, the insurance commissioner who had approved PIE's entry into that state's market (over the objections of competitors who'd questioned the company's financial stability) left office the following year to become PIE's vice president for governmental relations.

PIE was equally skillful in cultivating the state's medical establishment. In 1994, the company received an official endorsement from the Ohio State Medical Association, in exchange for an annual payment of more than $10,000. PIE proudly displayed that official blessing in full-page ads on the back page of the association's monthly magazine. According to Brent Mulgrew, OSMA's executive director, the endorsement "seemed like a good idea at the time," since the majority of OSMA's members were then covered by PIE, and most were apparently satisfied with the company's service. (OSMA canceled its endorsement last fall, just before PIE's collapse.)

Things fall apart

Gerald Leeseberg, a Columbus plaintiffs' attorney who's monitoring the PIE affair for the Ohio Academy of Trial Lawyers, believes that the same factors that fueled the company's rapid growth may have caused its downfall.

"They started out being very selective," says Leeseberg, "signing up only low-risk, highly qualified doctors. But then they tried to expand quickly by offering low premiums and signing up everyone they could, including lots of high-risk doctors. They were so successful at it that when the claims started mounting they were overwhelmed."

For a while, PIE managed to hide its financial problems. The image of corporate prosperity was helped by generous salaries and benefits for senior managers. According to one survey, PIE's payroll and travel expenses ranked highest among the country's 50 largest malpractice carriers.

"PIE's rates were always too good to be true, and doctors should have known better."

David Scroggins
Practice management consultant, Cincinnati

But when examiners from the Ohio Department of Insurance finally took a close look at PIE's books last June, they found that the company had overstated its surplus by nearly $100 million. When PIE failed to file its quarterly financial statement last fall, ODI placed the company under regulatory "supervision." Since that action was confidential, however, PIE-insured doctors didn't hear about it.

What they did hear about in late 1997 was PIE's plan for a "strategic alliance" with The Doctors' Company, a large national carrier. Several thousand physicians in Cincinnati, Columbus, and Dayton were simply informed by their insurance agency that their policies were being "transferred" to The Doctors' Company. That carrier, however, generally charged higher premiums to renew the policies, and would not accept liability for pending claims covered under the old PIE policies.

As they dug deeper into PIE's records, Ohio Department of Insurance investigators discovered a pattern of generosity among the company's top executives that seemed surprising, given its dire financial condition. According to a complaint later filed by ODI in Franklin County Court, in the fall of 1997, PIE had made payments totaling $11.5 million to President Larry Rogers, Treasurer James Marietta, and General Counsel Warren Udisky — all without the knowledge or approval of the board of directors. These "golden parachute" payments were intended to compensate the officers in case the company changed hands. While that hadn't happened, the money had been paid anyway. (ODI has since sued the three officers, demanding that they return the $11.5 million.)

According to the ODI complaint, Rogers had also borrowed $1 million from a PIE subsidiary "for personal reasons" (the loan was later "improperly forgiven") without the board's approval. In addition, the complaint asserts, Rogers had received a still-outstanding cash advance from PIE of $264,000.

Based on its investigation, the Ohio Department of Insurance sought a court order last December placing PIE and its assets under state control, arguing that the company's "hazardous financial condition" endangered its creditors and physician policyholders. To justify its request for immediate action, ODI claimed "reasonable cause" to believe that PIE's solvency was threatened by the possibility of "embezzlement, diversion of assets, forgery, or fraud."

The court granted the request, putting a 90-day stay on all litigation involving the company, including pending malpractice claims. The court order prohibited the company from writing new or renewal policies, settling any claims, or paying any bills. The court also authorized ODI to investigate PIE officers suspected of financial misconduct.

Any criminal charges against Rogers could prove embarrassing, since they may involve state prosecutors whose boss, Attorney General Betty Montgomery, had received $72,000 in campaign contributions from Rogers. Another source of potential embarrassment is ODI's former deputy director, David Randall. According to Ohio's Inspector General Richard Ward, state investigators have been looking into whether Randall may have shielded PIE's financial troubles from disclosure in exchange for gifts from the company.

In news interviews, Rogers blamed PIE's troubles on various factors: increased competition from other carriers; a $14 million loss from the purchase of a Texas insurance company that later failed; and a rush of malpractice suits filed early in 1997, just before Ohio's new tort reform law took effect. In an effort to calm creditors and policyholders, Rogers insisted that the company had plenty of money to cover its liabilities, and that its financial outlook remained "fine."

PIE's board of directors was not convinced. In December it fired Rogers, Marietta, and Udisky, and replaced the board's chairman, Cleveland neurosurgeon Herbert Bell. The board also severed the company's ties with Jacobson, Maynard, and Tuschman, the law firm that had handled all its malpractice claims.

Last winter, after concluding that PIE was actually $270 million in debt, ODI requested court authorization to liquidate the company. In March, the court approved PIE's liquidation and extended the stay on malpractice claims for another six months. That will allow the state to sell PIE's assets and use the proceeds to pay the company's creditors as well as successful claims against its policyholders.

Doctors are suddenly at risk

For PIE's 15,000 policyholders, the company's collapse may cost much more than their lost premiums and the purchase price of replacement coverage. Since PIE was

a mutual company, each policyholder was also a shareholder, with a personal stake in the company's financial success — or failure. With its demise, they lost the prospective dividends they would have received, along with the "surcharges" they had paid over the years to boost the company's sagging capital reserves.

But the biggest potential victims of PIE's demise are the physicians named in 4,250 outstanding claims filed under their old policies. They may now be personally at risk for part of any settlements or judgments arising from those cases. Some of these doctors only learned about their exposure when they were notified that banks had stopped payment on PIE checks issued to cover settlements.

> ***"None of us relishes the idea of going after a doctor's assets because of PIE's mismanagment. But if we have to, so be it."***
>
> Gerald Leeseberg
> Plaintiffs' attorney, Columbus

Just before the collapse, for example, PIE had settled a claim against an emergency physician in Springfield, Mo., for $200,000. The physician, who prefers not to be named, is wondering who's going to pay the settlement. "I'm afraid the plaintiff's attorney will come after me for the money," he says, "and I'm scared to death because I'm not covered now. The PIE lawyer who'd been defending me hasn't been paid since November, and I can't afford to pay him myself."

Given the size of his settlement, this doctor probably shouldn't worry. Under liquidation, all claims against PIE-insured doctors will be covered by each state's insurance guaranty fund, financed by carriers doing business in those states. But since each fund has a cap — ranging from $100,000 per claim in Kentucky to $300,000 in Ohio — PIE policyholders could be liable for any settlements or judgments above those amounts.

According to Cincinnati defense lawyer Michael Lyon, "PIE's liquidation means that plaintiffs' lawyers in Ohio will be faced with the state fund's $300,000 limit. If they've got judgments or settlements against doctors for $500,000 or so, they may be willing to accept $300,000, figuring it's not worth the time and effort to go after the doctor for the rest. But if there's a chance of a multimillion-dollar recovery, that's a different matter."

Lyon represents a PIE-insured neurosurgeon recently hit with a $2.5-million malpractice verdict. While Lyon hopes to get that judgment reversed on appeal, PIE's collapse has left the physician feeling understandably vulnerable.

Lyon says that plaintiffs' lawyers rarely go after doctors' personal assets, preferring to get their money from an insurance company. "But this situation is different," he explains, "because of what's happened to PIE. With a multimillion-dollar judgment, if there are no co-defendants with deep pockets, the doctor may be personally at risk."

Richard Goldberg is a Youngstown plaintiffs' attorney whose firm has 15 cases pending against PIE-insured physicians. He expects some of those cases to end in judgments or settlements of more than $1 million. In one, the medical bills alone run over $2 million. Are the doctors themselves at risk in these cases?

"Absolutely," says Goldberg. "In Ohio they're exposed for any judgment or settlement over $300,000, and there's no way we'll settle these cases for that amount. Of course, we'll go after any co-defendant physicians first, particularly if they're not covered by PIE. And we'll sue the hospitals on the grounds that the doctors are their agents.

"But if we can't make a case against the hospital or any co-defendants, and if there's no other way to get the money to pay our clients' medical bills and to compensate them for their injuries, we'll certainly go after the defendant doctor. If I have to choose between letting him keep his personal assets and getting my client what she deserves, I'm going to go after the doctor, even if that means bankrupting him."

"None of us relishes the idea of going after doctors' personal assets," says Columbus plaintiffs' attorney Gerald Leeseberg, who also has several cases pending against PIE-insured physicians. "Let's face it, that makes us look bad. So we don't want to bankrupt a physician because of PIE's mismanagment, particularly if there are co-defendants we can go after. But it's our duty to obtain the compensation our clients are entitled to. And if that means going after the doctor's assets, so be it.

"Of course," says Leeseberg, "most specialists who practice high-risk medicine have probably protected their personal assets, so there's no way we're going to get a $2 million judgment out of them. But we may demand some personal payment from them if we agree to settle for less."

St. Louis defense attorney Robert Seibel represents a dozen PIE-insured physicians facing potential multimillion-dollar claims. Among them: an ER doctor who's being sued by an 18-year-old quadriplegic, an Ob/Gyn with a brain-damaged baby case, and an orthopedic surgeon faced with a spinal injury claim involving severe neurological damage. Even with Missouri's $500,000 cap on non-economic damages, the medical costs and economic damages in each of those cases could easily run well into the millions.

"PIE's liquidation is bad news for the plaintiffs' lawyers in those cases," says Seibel, "because it's a lot easier for them to get the money from the insurers than from the doctors. Most doctors don't have millions of dollars in assets, and those who do are usually judgment-proof, because their assets are protected. If there are no co-defendants or hospitals and they come after us," Seibel says, "we'll either settle the case within the guaranty fund limit or go to trial and hope we win."

Plaintiffs' lawyers in Ohio are naturally upset by PIE's liquidation because it may limit their recovery in cases against PIE-insured doctors to the state fund's cap of $300,000 per claim. That cap, of course, would also limit their 30 to 40 percent contingency fee to about $100,000, which is much less motivating than an equal percentage of a million-dollar verdict or settlement.

Plaintiffs' attorneys also fear liquidation, because the process of bringing cases to the state guaranty fund can be even more exhausting than usual litigation. "The last time I got involved with a liquidation, it took eight years for my client to get anything," says Goldberg.

For those reasons, some plaintiffs' lawyers are reportedly waiting until PIE's doctors find new insurance before filing their claims. They know it will be much easier to negotiate settlements up to the doctors' new policy limits than to go after their personal assets.

The fallout is widespread

PIE's collapse threatens far more doctors than the thousands who face pending claims. Under joint-and-several liability laws in Ohio and some other states, plaintiffs' attorneys can recover the bulk of a malpractice judgment from any co-defendant, even if he's only marginally responsible for the injury. Many hospitals are also nervous, fearing that plaintiffs' attorneys with claims against PIE doctors will be looking hard for deeper pockets. (Because of what happened to PIE, many Ohio hospitals now require all staff physicians to carry insurance with top-rated companies.)

Thousands of PIE-insured doctors who've recently retired are also vulnerable because their "tail" coverage (for claims arising from prior years of practice) may now be worthless. Few carriers will write separate tail policies for retired doctors, and those that do generally charge a lot for it. The cost can run from 50 to more than 150 percent of the prior annual premium, depending on the doctor's specialty, his previous claims records, and the number of years since his practice ended.

Tail rates for retired Ob/Gyns and pediatricians are particularly high because they face more years of exposure than other physicians. One retiring orthopedic surgeon with a record of several settlements will now have to pay more than $120,000 for separate tail coverage, four times his former annual premium with PIE.

As with most financial disasters, this one has generated numerous legal claims against the company. While most PIE-insured doctors simply swallowed their losses and rushed to buy replacement coverage, some are fighting back. More than a dozen have filed suits — some of them class actions — seeking compensatory and punitive damages against PIE, its top officers, directors, accountants, lawyers, and agents, charging them with everything from mismanagement and negligence to outright fraud.

According to one knowledgeable source, PIE's two dozen physician directors were shocked to discover that the company had allowed their own liability coverage to lapse last year, leaving them personally exposed to damage claims by angry policyholders. Several suits accuse Acordia of Ohio, PIE's exclusive agency, of selling renewal policies to thousands of physicians through the fall of 1997, long after it "knew or reasonably should have known" of the carrier's financial difficulties.

> ***"Most doctors liked PIE's law firm so much that they overlooked the drop in the company's ratings."***
>
> Lance Talmage, M.D.
> President, OSMA

Since PIE was its only client, the firm of Jacobson, Maynard, and Tuschman is now basically out of business. Its 15 offices in six states have closed, and its 90 lawyers have joined other firms or opened shop on their own. For several months after PIE's collapse, many of them continued to represent PIE-insured doctors with outstanding claims, hoping their fees would eventually be paid by the state guaranty fund, by the doctors themselves, or by the new carriers they sign up with. Unfortunately for those lawyers and their doctor clients, the Ohio guaranty fund has decided to assign their cases to other firms, whose lawyers will have to start from scratch.

For most physicians, the search for new coverage has not been difficult. In fact, there's been a feeding frenzy among malpractice carriers trying to sign up the thousands of doctors left bare by PIE's sudden demise. Because of the intense competition, some companies are offering to match PIE's former low rates — until renewal time — and are including "prior acts" coverage at little or no extra cost. Others are charging substantially more.

While these companies may be leery about the potential danger of "prior acts" claims, the chance to pick up thousands of new policyholders — or the fear that a competitor will — makes them willing to bear that risk as the cost of getting the new business. None, however, are willing to cover existing claims.

For that reason, some PIE doctors who face pending claims are quietly transferring ownership of their assets, often to their spouses. But that ploy probably won't work. According to malpractice lawyers, courts will not recognize asset transfers "made upon or in anticipation of" being sued. (Cynics warn that doctors who try to protect their assets by transferring them to a spouse may create an even greater risk of losing them through divorce.)

Who should have known, and when?

One of the most suprising things about PIE's collapse is how may people should have seen it coming but didn't, despite numerous warning signs. In fact, there's enough embarrassment, blame, and guilt to go around for everyone: doctors, lawyers, accountants, insurance agents, medical leaders, and government officials.

Unlike most PIE-insured physicians, Columbus orthopedist Edwin Season had been monitoring the company's finances for years. When he heard rumors from his insurance broker in mid-'96 (more than a year before the collapse) that PIE's financial reserves were low, he switched to another carrier. "I really didn't have any great insight," he says. "I was just lucky I got out in time."

Season puts part of the blame for PIE's failure on its board of doctor directors. "They're probably all good doctors," he says, "but as directors, they apparently weren't doing the job they were supposed to do: supervising the company's management."

"Doctors can't rely on insurance agents alone. They may have to start doing more research themselves."

Pamela Popp
Defense attorney, Cincinnati

Unfortunately, most PIE-insured physicians didn't know what was going on at the company's headquarters; or perhaps they just didn't care because their premiums were so low. Those who did care could easily have checked PIE's ratings with several research firms that evaluate the financial stability of insurance companies (see page 191). A. M. Best, the most commonly cited service, had downgraded PIE from B+ to B in 1995, and then to B- in mid-'96, based on three years of operating losses and questionable real estate investments. Best dropped the rating to D ("poor") only in November 1997, just before the collapse, due to "unstable loss reserve trends." Weiss Ratings, known for its tough evaluations, had been giving PIE ratings of E+ ("very weak") since 1994.

When Matthew Kurlan, an emergency physician in Loveland, Ohio, heard that Best had lowered PIE's rating to B-, he was concerned enough to call his insurance agent. "He told me not to worry," says Kurlan. "Looking back now, I realize I should have worried. Fortunately, I have no claims pending against me — yet."

Lance Talmage, a Toledo Ob/Gyn and president of the Ohio State Medical Association, says he and his colleagues were satisfied with PIE's coverage until the company's Best ratings began to fall in mid-'96. Even then, he says, "most doctors liked PIE's law firm so much that they overlooked the drop in the ratings."

For anyone who had bothered to look, there were plenty of other signs of PIE's trouble. Back in 1994, all PIE policyholders had been notified that as shareholders of a mutual company they would have to pay a 7 percent surcharge for each of the next three years to boost capital reserves and "to ensure the long-term stability of the company."

Then there's the matter of PIE's low premiums. "PIE basically bought their business by undercutting the other carriers," says David Scroggins, a practice management consultant in Cincinnati. "Their rates were always too good to be true, and doctors should have known better.

"The problem is that most physicians just buy the cheapest policy they can find without examining what they're getting or how that company is rated," Scoggins says. "They should be willing to make an effort to find out more about the carriers, and to pay more for a better product."

Most doctors defend their choice of PIE by explaining that they rely on their insurance brokers to handle their liability coverage, and to alert them if the company is in trouble. But as PIE's collapse illustrates, such reliance may be naive. Some brokers simply didn't know about PIE's troubles in time to warn their clients. Others may have ignored evidence of PIE's predicament, because they were blinded by their exclusive deals with the big carrier. Since the arrangement was lucrative, and since most doctors readily renewed their policies without comment, the brokers apparently weren't motivated to question PIE's financial stability.

Youngstown attorney Richard Goldberg feels PIE-insured physicians have good grounds for blaming their insurance agents for not protecting them against the company's collapse. "Reasonable due diligence would have suggested getting the doctors out of PIE long before the collapse," he says. "The agents are supposed to keep track of these things." That's one reason they're paid a commission."

Those agents and Ohio insurance officials should have been concerned in March 1997, when the state of Texas declared PIE's subsidiary, Insurance Corporation of America, insolvent and shut it down. In a forewarning of what happened later in Ohio, that action left 3,900 physicians in Texas and other states scrambling to find new coverage at rates up to 30 percent higher than they'd been paying to ICA.

When the dust finally settles, the state guaranty funds should be able to cover the majority of outstanding claims, since most malpractice cases are typically closed with little or no payment except the cost of defense. And now with PIE's liquidation, plaintiffs' lawyers will probably encourage most of their clients to settle for the state fund limits, rather than face years of litigation with no assurance of getting more.

It's still not clear, however, if doctors have really learned any lessons from PIE's collapse. "I doubt if it's going to be the last time this happens," says George

Lehmann, whose Toledo insurance agency had sold PIE policies to hundreds of physicians. "The malpractice market has become so competitive that many carriers have been cutting their prices in order to gain a bigger share. At the same time, a lot of doctors are now in IPAs that can negotiate lower group rates from companies that want their business.

"But the fact that those doctors are now in IPAs doesn't mean that they've changed the way they practice, or that they face less risk of being sued. So the companies that cover them are going to be getting the same number of claims but earning less money. That could cause more instability in the industry, with more companies going under."

Five steps to choosing the right malpractice carrier

In the wake of PIE Mutual Insurance Co.'s collapse, thousands of physicians are now wondering why they didn't see it coming, why they weren't warned in time, and how they can avoid such disasters in the future. While there may be no crystal ball, there are ways to protect yourself. Here's some advice from experts:

1. Don't buy on price alone

Carol Golin, editor of the monthly newsletter *Medical Liability Monitor*, warns physicians against choosing a malpractice carrier merely because its premiums seem like a bargain. "Most doctors only look at the price when they're buying malpractice insurance," says Golin. "That's understandable, since it involves a big chunk of money. But they should also pay attention to what they're getting for their money, because it can make a big difference if they're sued or, worse, if the company goes under.

2. Ask your agent tough questions

Pamela Popp, a Cincinnati health-care attorney, feels doctors should question their insurance agents more carefully about the carriers they recommend. "Because of agents' supposed knowledge," she says, "doctors should expect agents to protect them from getting involved with an unstable company. After all, that's why you use a broker, and why you pay a commission. Brokers have a fiduciary relationship with their insureds, especially with busy professionals like doctors who don't have the time or the knowledge to study the carriers' finances and ratings."

3. Do your own research

As the PIE debacle proves, relying on insurance agents alone may be unwise, and doctors may have to start doing more research themselves. "It's become part of the business of practicing medicine these days," says Popp.

One place to begin is your state insurance department. Ask if it has received any complaints about your carrier, or if the carrier is under any kind of regulatory supervision. If your malpractice insurer is a publicly held company, you should follow its stock price, says Michael Brown, a practice management consultant in Indianapolis. Price movement can reflect major problems.

Brown also suggests asking the agent or the company itself for a copy of its annual report or a profit-and-loss statement. If you don't understand such information, find someone who does. "Even if you review all that data carefully," Brown warns, "a company can still hide its troubles for quite a while if it wants to, particularly if it's privately held."

4. Check your carriers' ratings

Any good medical or public library should carry the publications of one or more of the services that evaluate insurance carriers' financial stability. A.M. Best ratings are the most widely known, but Standard & Poor's, Duff & Phelps, Moody's, and Weiss Ratings offer similiar data. If your carrier doesn't get good ratings, ask your agent about switching to one with better grades.

According to a study by the U.S. General Accounting Office, Weiss's evaluations are generally tougher than those of its competitors, and give earlier warnings of carriers' financial troubles. Weiss's low ratings of PIE since 1994 support that comparison. Weiss explains its rigorous evaluations by claiming that it's the only research service that's not paid by the companies it rates, so it doesn't have any incentive to suppress unfavorable ratings. (To contact Weiss Ratings, call 800-289-9222 or visit its Web site *(www.weissratings.com)*.

5. Other sources of information

One good source of independent information on malpractice carriers is the monthly newsletter *Medical Liability Monitor*, available in many medical libraries. (To subscribe, at $170 a year, write to MLM at P.O. Box 316, Glenview, Ill. 60025, or call 312-944-7900.)

The AMA has just published a revised edition of *"The Guide to Medical Professional Liability Insurance,"* an excellent handbook that includes a useful chapter on evaluating the financial condition of malpractice carriers. (Available from AMA, P.O. Box 7046, Dover, Del. 19903, or call 800-621-8335. It costs $29.95 for AMA members, $39.95 for non-members, plus $6.95 for shipping and handling. Order #OP 631291.)

Attitudes about cancer pain: A survey of 727 health care professionals in West Virginia

STEVEN J. JUBELIRER, M.D., F.A.C.P.
Senior Research Scientist, Camcare Health Education and Research Institute; and Clinical Professor, West Virginia University School of Medicine, Charleston Division, Charleston

CAROLYN S. WARREN, M.D., F.A.C.P.
Medical Director, Kanawha Hospice Care, Inc., Dunbar

ROBIN RECTOR, M.A.
Director of Continuing Education and Conference Services, Camcare Health Education and Research Institute, Charleston

GLADYS KUHN, R.N.C., B.A.
Corporate Director of Oncology, Charleson Area Medical Center, Charleston

SUZANNE WALTON, PHARM.D., BCPS
Clinical Pharmacist Specialist in Oncology, Charleston Area Medical Center, Charleston

CHRIS ZINN, R.N., C.R.N.H.
Kanawha Hospice Care, Coordinator of Provider Relations, Kanawha Hospice Care, Inc., Dunbar

Abstract

To assess the attitudes of health care professionals in West Virginia about cancer pain, we utilized an 11-item questionnaire developed by DeWiessman and T. L. Dahl. We administered this questionnaire to 727 health care professionals and chi-square tests were used to assess correlations between attitudes on cancer pain and demographic characteristics (e.g. age, family history of cancer, sex, etc.). The majority of respondents believed that greater than 60% of cancer patients experience pain and that most patients were undermedicated with respect to pain. Age and having a family member with cancer were the major factors affecting attitudes. Respondents less than 46 years old compared to those 46 or older, were more likely to believe that most cancer patients were undermedicated; that addiction to narcotics is rare; and that the patient is the best judge of cancer pain intensity. Respondents with a family member with cancer were less likely to be concerned about addiction if a family member is given morphine. We conclude that educational efforts should be directed at altering attitudes regarding cancer pain in individuals age 46 years or older and those without a family history of cancer.

Introduction

During the past 25 years, increasing attention has been given to the undertreatment of cancer pain. In the United States, numerous barriers have been identified that have prevented patients from receiving effective pain treatment and have prevented health care professionals from providing such treatment (1-5).

Several studies have shown a lack of understanding in both the theoretical and practical aspects of analgesic therapy in cancer pain management (6-9). Physician/patient communication about pain symptoms has been shown to be problematic, with physicians consistently underestimating the patient's physical components of pain and overemphasizing the psychological components (10).

In order to remedy this situation, numerous organizations such as the American Pain Society, the American Society of Clinical Oncology (ASCO), the Oncology Nursing Society (ONS), and the National Cancer Institute (NCI), have developed curricula and guidelines for the treatment of cancer pain (11-14). Also, at least 47 states, including West Virginia, have started cancer pain initiatives to increase awareness and disseminate information on the adequate treatment of cancer pain (15).

Our study reports the responses to a survey administered to 727 health care professionals in West Virginia and it was designed to:

1. identify any knowledge deficits and/or negative attitudes that should be addressed by cancer pain initiatives' educational efforts; and
2. identify any particular groups to which these efforts should be directed.

Methods

An 11-item questionnaire developed by Weissman and Dahl (11) (Table 1) was sent to 4,214 health care professionals (HCPs); a total of 727 (17%) were returned.

Chi-square and Mantel-Haenszel Chi-square tests were used to assess correlations between responses to questions and demographics such as health care profession, age, sex, personal or family history of cancer, and number of years since completing professional training.

Results

Of the 727 HCPs responding, 561 (77%) were physicians; 91 (12.5%) were nurses; 47 (6.5%) pharmacists; and 28 (4%) were social workers.

Table 1. Demographic Characteristics of the 727 Health Care Professionals Answering the Questionnaire.

Sex	
Male	65%
Female	35%
Race	
Caucasian	80%
Asian	15%
African-American	3%
Age (years)	
26 - 35	7%
36 - 45	32%
46 - 60	38%
> 60	22%
Years since completing training	
1-5	7%
6-10	12%
11-15	18%
16-25	30%
> 25	33%
Percentage of individuals who had cancer or a family member with cancer	
Yes	63%
No	37%
Percentage of individuals who had taken pain killers or those who had family members who had taken pain killers	
Yes	43%
No	57%

Table 1 shows the demographics of those responding. Thirty-nine percent were 45 years old or less, and 61% were 46 years old or older. Sixty-five percent of respondents were male and 35% were female. Sixty-three percent of respondents had a personal or family history of cancer. In addition, 63% percent had completed their professional training 16 or more years earlier.

The majority of respondents (88%) felt that pain was experienced by greater than 60% of cancer patients. Eighty-eight percent believed that the majority of cancer patients were undermedicated. Furthermore, 90% stated that the patient was the best judge of cancer pain intensity.

The major factors associated with differences in responses or attitudes were age and personal or family history of cancer. Those respondents age 45 or younger, compared to those age 46-years or older, were more likely to believe that:

1) Most cancer patients were undermedicated with respect to analgesics (91% vs. 79%, p = .001);
2) Addiction to narcotics for cancer pain is rare (55% vs. 38%, p = .001) and;
3) The patient is the best judge of cancer pain intensity (94% vs. 85%, P = .001). The younger respondents were also less likely to be concerned about a family member becoming addicted to morphine for cancer pain (61% vs. 51%, p = .009).

The answers also showed that the respondents who had a personal or family history of cancer vs. those who did, were more likely to:

1) believe that cancer patients were undermedicated (85% vs. 78%, p = .001); and
2) be concerned about addiction if a family member with cancer is given morphine (59% vs. 45%, p = .001).

Discussion

The response rate for this survey of 17% was less than desirable. The response rate was 28% in a similar survey in North Carolina (16) and 49% in an Eastern Cooperative Oncology Group (ECOG) survey (17).

There is a possibility that the results could be affected by respondent bias since those who responded were more aware of cancer pain control from experience in their practice or in their family. The increased response rate in the ECOG survey (17) among HCPs with a personal or family history of cancer is consistent with this theory. This possible bias might affect the overall responses, but it still may not account for the differences seen after demographic stratification. Although the results of our study should not be considered representative for the population surveyed, they are valuable in that they represent the only indication to date of the knowledge regarding cancer pain and attitudes of health care professionals in West Virginia.

The responses to this study indicate that the majority of HCPs perceptions regarding cancer pain were accurate. Most individuals questioned knew that cancer pain is common, and that it is often undertreated. They also believed the patient to be the best judge of cancer pain intensity. These concepts are consistent with prior findings that 60% of cancer patients experience pain and that 50%-80% of patients are undermedicated (18).

However, the perceptions of the respondents varied significantly between certain subgroups. Those who were 46 years old or older and those with no personal or family history of cancer were less likely to believe that cancer patients are undermedicated and that the patient is the best judge of pain intensity. Therefore, the educational efforts of the West Virginia State Cancer Pain Initiative might be well spent if directed toward these groups.

The individuals less than 46 years of age who responded had a much greater likelihood of correctly estimating the percentage of cancer patients who are undermedicated, and of having the attitude that the patient is the best judge of cancer pain intensity. The explanation for this finding is unclear, but it may be due to more recent emphasis on cancer pain management in both health care training programs and in the medical literature.

However, knowledge alone does not lead to changes in behavior and education by itself is not enough. This is particularly true when trying to teach symptom management; medicine is organized around categories of diseases, not symptoms, and medical education has not given priority to teaching treatment of symptom complexes (19). Integrating pain management into routine practice should be emphasized. This can be done by such acts as making pain visible as the fifth vital sign and by recording pain intensity on the patient's daily flow sheet routinely. These actions facilitate the translation of symptom assessment into practice. Pain is more likely to be treated if it is measured and recorded.

There is a pressing need to ensure that pain management is a priority in health care delivery systems. The public's fear of pain and the media's portrayal of physician-assisted death and euthanasia as options for relief of pain in cancer patients should exhort force us to urge that health care delivery systems be committed to improving pain relief (20).

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Right ventricular endocarditis due to infection of pacemaker apparatus

ANURAG MEHTA, M.D.
Assistant Professor of Medicine, Section of Cardiology, West Virginia University School of Medicine, Morgantown

MELANIE ANN FISHER, M.D.
Associate Professor of Medicine, Department of Medicine, West Virginia University of Medicine, Morgantown

ABNASH C. JAIN, M.D.
Professor of Medicine, Section of Cardiology, West Virginia University of Medicine, Morgantown

GEOFFREY GRAEBER, M.D.
Professor of Surgery, Department of Surgery, West Virginia University of Medicine, Morgantown

MAHAVEER MEHTA, M.D.
Research Faculty, Section of Cardiology, West Virginia University School of Medicine, Morgantown

Abstract

This article describes an unusual case of endocarditis in a 73-year-old man with a permanent pacemaker. Echocardiography revealed vegetations in the right ventricle below the tricuspid valve only, and he required open heart surgery for removal of the pacemaker system. This case demonstrates the potentially protracted course of infective endocarditis many years after pacemaker insertion. It also emphasizes the importance of echocardiography in diagnosing right ventricular vegetations; and the need for total replacement of the endocardial pacing system whenever it becomes infected.

Introduction

Infective endocarditis is an unusual complication of permanent pacemakers (1). We report a case of infective endocarditis with a protracted course after permanent pacemaker insertion. This is the first reported patient we know of in which vegetations and thrombus were found around the pacemaker leads in the right ventricle without involving the tricuspid valve (2,3).

Transesophageal echocardiography facilitated evaluation of the infected thrombus and large vegetations. Surgery was performed to remove the embedded pacer and vegetations.

Case report

A 73-year-old man with diabetes mellitus who had undergone pacemaker insertion for hypersensitive carotid syndrome seven years earlier in another hospital was brought to Ruby Memorial Hospital in Morgantown with fever, rigors and leukocytosis.

This patient's history revealed he had developed "blisters" over his pacemaker generator about five months earlier. His pacemaker had been replaced at the other hospital about two months later after the skin lesions appeared due to persistent infection despite several courses of oral antimicrobials. He had been well until his present symptoms.

He had no history of any recent dental or outpatient surgery. Multiple blood cultures were negative. A CT scan of the chest was normal. His fever persisted and he was admitted.

There was no peripheral stigmata of infective endocarditis. No erythema, fluctuation or drainage was present, but the generator site was mildly tender where his incision had healed. No heart murmurs were heard. The white blood cell count was 13,000/ml.

Propionibacterium species, which was sensitive to vancomycin, grew in one of the many sets of blood cultures obtained and was judged to be a contaminant. The organism was sensitive to vancomycin and he received six weeks of preoperative intravenous vancomycin. The fever resolved and he began feeling better. A single-plane transesophageal echocardiogram revealed a 3 x 1 cm mass associated with the pacemaker wires in the right ventricle projecting through the tricuspid valve (Figure 1).

Surgery was performed. Coagulase negative staphylococci grew from the intraoperative sample and specimen. The surgeon preferred open removal to intravascular extraction and surgery was therefore undertaken using cardiopulmonary bypass. The right atrium was opened and the tricuspid valve inspected. The right atrial cavity and the atrial surface of the tricuspid valve were normal. A thrombus around the pacemaker projected from the right ventricle through the tricuspid valve.

With great difficulty, the pacing wire with a tented thrombus knitted around the catheter was extracted from the right ventricle. The right ventricle and tricuspid valve were intact. The thrombus was tangled below the papillary muscle of the tricuspid valve in the musculature of the right ventricle. The right atrium was normal. Temporary epicardial atrioventricular pacing wires were placed on the surface of the heart and the patient was weaned from cardiopulmonary bypass.

The next step was to place a pacing generator in an abdominal pocket. The left subclavian fossa was opened to pull the pacemaker wires from the subclavian system and the pulse generator was delivered. The temporary epicardial wires were replaced by an active fixation endocardial system from the right side.

Pathological examination of the specimen revealed thrombus formation with areas of infiltration with neutrophils and partial organization (Figure 2). Tissue from the surgical specimen grew coagulase negative staphylococci sensitive to vancomycin. The patient was given IV vancomycin for six more weeks and recovered completely.

Discussion

More than one million pacemakers and 10,000 automatic internal cardioverter defibrillators (AICDs) were implanted worldwide in 1990 alone (4). Infective endocarditisis is an uncommon complication of permanent pacemakers; the true incidence is unknown. Stryker and Palmer (5) reported an incidence of 1%; Wade and Cobbs (1) estimated an incidence of 0.1 to 3%.

When the diagnosis of infection of the pacemaker pocket was made, the entire pacemaker system should have been explanted. The approved treatment at that time was to perform intravascular lead extraction (7) of the right ventricular wire, to give antimicrobials for six weeks (8), and to place a new right-sided endocardial pacemaker system (9). This might have prevented spread of infection along the lead system with subsequent endocarditis. An alternative approach might have been a closed irrigation system to salvage the infected pacemaker pocket (10).

The diagnostic accuracy of transthoracic echocardiography is similar to that of transesophageal echocardiography in right-sided endocarditis among intravenous drug users (11). In our patient's case, however, transesophageal echocardiography allowed a more extensive evaluation of the pacemaker lead, right atrium, right ventricle, and superior vena cava and particularly aided in delineating the unusual location of vegetations.

Unlike other reported cases, our patient had vegetations only in the right ventricle, with the tricuspid valve unaffected. Both transthoracic and transesophageal echocardiograms revealed the exuberant vegetations and strongly suggested the diagnosis of infective endocarditis. Although, transesophageal echocardiograms help identify the mass, they may not permit differentiation between vegetations and thrombus. CT scans of the chest may reveal vegetations in the superior vena cava or right atruim, but do not help to evaluate right ventricular lesions, as were present in our patient.

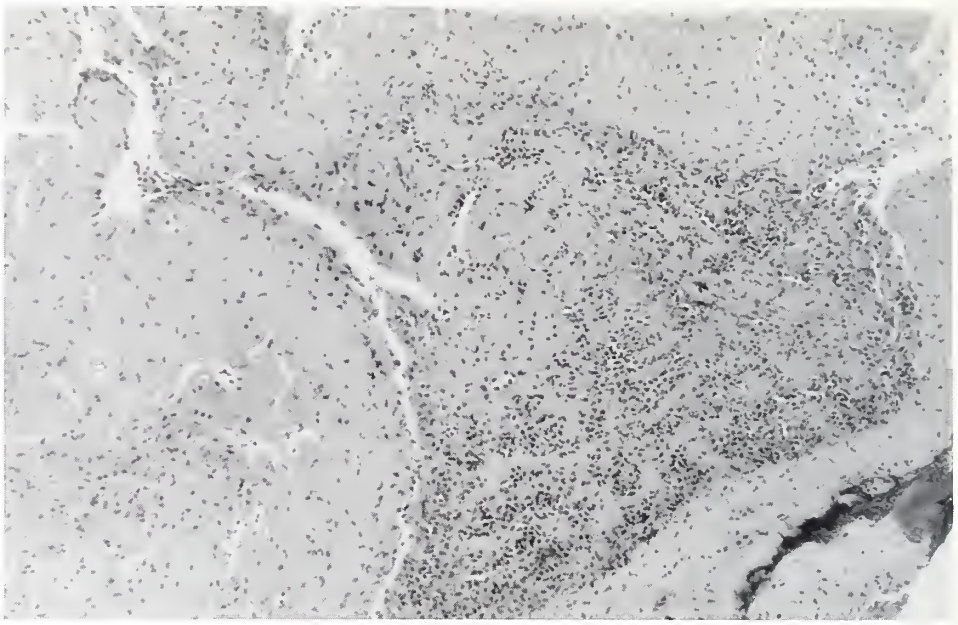

Figure 1. **Transeophageal echocardiogram of the esophageal four chamber view showing an echo-density attached to ventricular lead of a permanent pacemaker.**

RA = right atrium TV = tricuspid valve RV = right ventricle

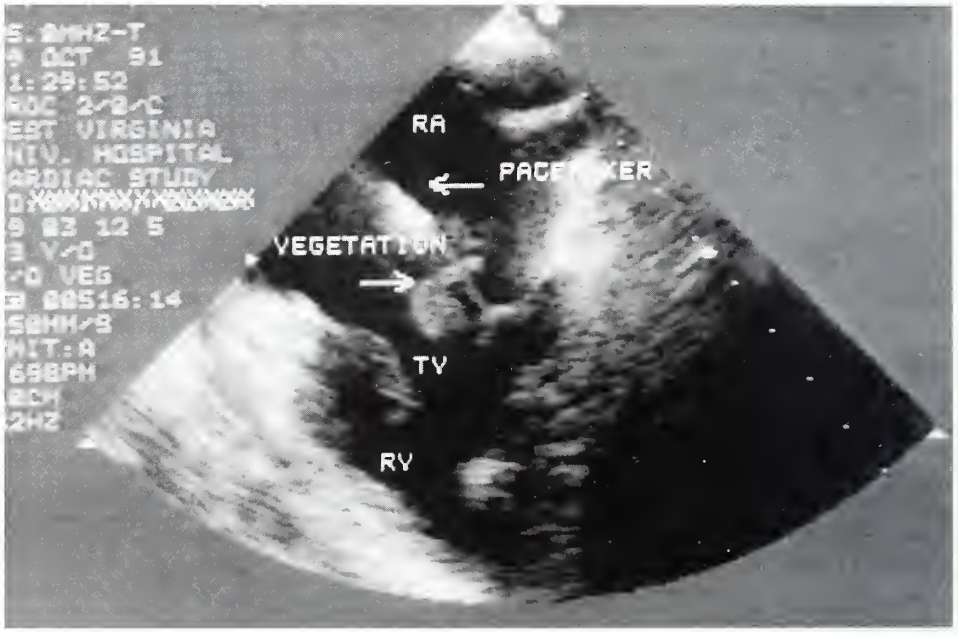

Figure 2. **Pathological specimen from right ventricle. Magnification x120. Hematoxylin and eosin stain. Vegetative material consists of partly organizing fibrin and blood clots with an area of acute inflammatory exudate.**

The long duration of the previously implanted leads, the protracted course of infective endocarditis, the concomitant risk of pulmonary embolism, and the possibility of perforation of a chamber to which leads were adherent induced the surgeon to opt for open heart surgery.

Conclusion

Staphylococcus species are the most common microorganisms causing pacemaker-associated endocarditis. Our patient's infective endocarditis was caused by coagulase negative staphylococci which grew from the intraoperative specimen. The infection probably began with surface erosion of the pocket site, followed by entry of bacteria through the skin, into the pocket along the leads into the heart.

Studies are needed to more clearly define the incidence of pacemaker infections, the utility of antimicrobial prophylaxis, and the optimal management of such complications. With an infected antiarrhythmic implantable device, immediate removal of the entire unit is recommended followed by six weeks of antibiotics.

Acknowledgement

We would like to thank William Chang, M.D., Ph.D. for his review of the pathological specimen and Jaimela Dulaney, M.D. for the echocardiographic report.

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William C Morgan, Jr. M.D., F.A.C.S.

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Obsessive-compulsive disorder following closed head injury

JAMES P. GRIFFITH, M.D.
Associate Professor of Internal Medicine and Psychiatry, Robert C. Byrd Health Sciences Center, Charleston Division, Charleston Area Medical Center, Charleston

MRIDULA KAMTHAN, M.D.
Resident Physician, Robert C. Byrd Health Sciences Center, Charleston Division, Charleston Area Medical Center, Charleston

Abstract

Obsessive-compulsive disorder (OCD) is a rare sequelae of closed head injury. Frontal, occipital and fronto-temporal injuries are frequent among reported cases. Response to treatment is often poor. This article describes a patient with OCD and reviews relevant anatomic, neurochemical and psychologic aspects of patients with this condition.

Introduction

Closed head injuries are a common clinical problem, resulting in over 400,000 hospital admissions annually in the United States. Over one million people are estimated to be suffering from the lasting psychiatric effects of these injuries (1).

Closed head injuries can result in a wide range of psychiatric disturbances. Amnesia, delirium, and psychosis are commonly encountered during the early phases of recovery from closed head injury, while cognitive impairment, mood disorders, personality changes, and sleep disorders are often seen as late sequelae (1-3).

A variety of factors are thought to contribute to the psychiatric consequences of closed head injury. Pre-existing psychiatric illness, premorbid personality, family stability, recent life events, age, prior brain disease or alcoholism may all adversely affect psychiatric disability following head injury.

The extent and location of the brain injury is naturally important, as may be the duration of post traumatic amnesia (1). The inferior portion of the frontal lobes and the anterior portion of the temporal lobes are the most frequently involved in closed head injuries; psychiatric disorders most commonly follow injuries to the temporal lobes, left hemisphere, and frontal lobes (2). Post traumatic intellectual impairment, emotional and psychosocial problems, and compensation/litigation issues all interact to affect psychiatric outcome following closed head injury (1).

Obsessive-compulsive disorder (OCD) is characterized by ego-dystonic persistent thoughts, images or ideas associated with repetitive stereotypic behavior. The estimated lifetime prevalence of OCD in the general population is 1.9%-2.5% (4), but it has only rarely been reported following closed head injury (5-13). This report presents the case of such a patient who was referred to Charleston Area Medical Center, General Division, for treatment.

Case report

A 52-year-old male with no previous psychiatric history was hospitalized at Charleston Area Medical Center for a closed head injury to the occipital area following a fall from the back of a truck.

During his one week hospitalization, this patient was troubled by headaches and vertigo. Skull X-rays, head CT, and EEG were normal. Brainstem auditory evoked potentials showing left sensorineural hearing impairment.

During the next several months after he was discharged, he developed symptoms of depression, obsessional thinking, compulsive behaviors, irritability, cognitive decline and became suicidal. He was obsessed with orderliness and would compulsively arrange items at home. Similar behaviors were observed during subsequent psychiatric hospitalizations.

Over the next four years, suicidal ideation and impaired functioning prompted several psychiatric hospitalizations and treatment at two head injury rehabilitation centers. Obsessional thinking, compulsive arranging, irritability, paranoid delusions, and persistent cognitive impairments characterized his chronic course. One EEG showed a few right temporal spikes; cranial MRI was normal. Treatment with a variety of medications including carbamazepine, tricyclic antidepressants, serotonin reuptake inhibitors, clomipramine, antipsychotics and benzodiazepines produced little improvement. Individual, group, family, behavioral and biofeedback therapies have been provided during his course as well.

Table 1. Reported Cases of OCD Following Closed Head Injury.

Author	Age	Sex	Injury	Unconscious	Latency	Obsession	Compulsion	Treatment Response	Associated Symptoms
Griffith & Kamthan	52	M	Occipital	1-2 mins.	8 Months	Contamination, Disorder	Cleaning, Arranging	Poor	Depression, Cognitive Impairment
Donovan & Barry	22	M	Anterior, Frontal, Basilar	NR	9 Months	NR	Cleaning, Counting	NR	Irritability, Reduced Initiative
McKeon et al	18	F	NR	2-3 mins.	6 Months	Contamination, Dripping Nose	Cleaning, Nose Cleaning	NR	Depression
"	37	F	NR	5 mins.	NR	Contamination	Cleaning	Resolved 4 Yrs. Later	Depression
"	16	F	Occipital	None	1 Day	Losing Something	Searching	NR	Depression
"	23	M	NR	10 Days	NR	Contamination	Checking, Brushing Teeth	Poor	Depression, Delusions
Drummond	26	M	Occipital	Briefly	5 Months	Doubt, Harming Self or Others	Counting, Checking Swallowing	Partial	Depression
Ames et al	66	M	NR	Several Hours	NR	Cleanliness	Grooming, Dressing	Poor	Depression, Anxiety
Kettl & Marks	21 (Injured at Age 3)	M	Anterior	NR	12 Years	Contamination	Hand Washing, Arranging	Poor	Cognitive Impairment, Behavior Outbursts
Jenike & Brandon	24 (Injured at Age 17)	M	L. Fronto-temporal, R. Temp.	1 month	1 month	Illness, AIDS	Washing	Good Response to MAOI	Depression
Adler	NR	M	NR	NR	NR	NR	NR	NR	NR
Kozol	NR	NR	NR	NR	NR	NR	NR	NR	NR
Hillbom	22	M	R. Frontal, L. Parietal	NR	2 Years	NR	Moving Right Hand	NR	Depression, Seizures
"	30	M	Occipital	< 1 hour	3 Years	Doubt	Verifying	NR	Depression
"	24	M	L. Temp, Parietal	NR	6 Years	Doubt	Checking	NR	Anxiety

Discussion

The patient in this report is one of 15 described in the literature who have developed OCD following a closed head injury (5-13)(Table 1). Many of these case descriptions are incomplete. Several of them were reported prior to the development of neuroimaging techniques or effective pharmacotherapy for OCD, making definite conclusions difficult.

Many factors contribute to the development of psychiatric sequelae following closed head injury. While older theories regarded OCD as primarily a "neurotic" disorder (2), more recent reports emphasize the neurochemical and neuroanatomical abnormalities that cause OCD. OCD has been noted as a feature of many neurologic disorders (Table 2) (4). These associations point to the pathologic involvement of the basal ganglion, particularly the caudate nucleus, as an important contributing factor in OCD. This is further supported by modern neuroimaging and positron emission tomography (PET) scanning studies of OCD patients. Decreased caudate volume (15), and increased caudate metabolic activity (16) have been noted in patients with OCD.

The frontal lobes appear to also be involved in the pathogenesis of OCD,

perhaps via their interaction with the caudate nucleus (Figure 1) (14). Surgical resection of frontal lobe tumors (17), frontal lobe degenerative processes (18), toxic insults to the frontal lobes (19), and penetrating injuries to the frontal lobes (2) have all been associated with the development of obsessive-compulsive symptoms.

Nine cases of patients with obsessive-compulsive features following closed head injuries specified the location of the injury. Occipital and frontal/frontotemporal injuries were the most frequently described. Occipital blows may often lead to frontal lobe damage via a contra-coup mechanism (1).

Duration of loss of consciousness following closed head injury has been found to be related to psychiatric outcome in some series. A wide range of duration of unconsciousness (none - 1 month) have been described among patients with OCD after closed head injury, but many had a relatively brief (< 1 hour) period of unconsciousness. Likewise a wide range of time periods (from one day to 12 years) have been reported between the injury and the onset of obsessive-compulsive symptoms. Among reported cases, the most frequent obsession was concern about contamination/cleanliness, followed by obsessional doubt. Compulsive cleaning and checking were the most common compulsions.

Very little information about response to treatment was reported, though many of these cases occurred prior to the development of effective treatment for OCD. What information is available indicates a rather poor response to whatever treatment was provided, and our patient also had a poor response to multiple trials of treatment. Depression was the most frequent psychiatric comorbidity among reported patients.

Table 2. Neurologic Disorders with Obsessive-Compulsive Features.
(Adapted from reference 14).

Involuntary Movement Disorders (i.e. Parkinson's Disease, Progressive Supranuclear Palsy)
Tourette's Syndrome
Sydenham's Chorea
Huntingdon's Disease
Hypoxic Brain Injury
Toxic Encephalopathy
Meige's Syndrome

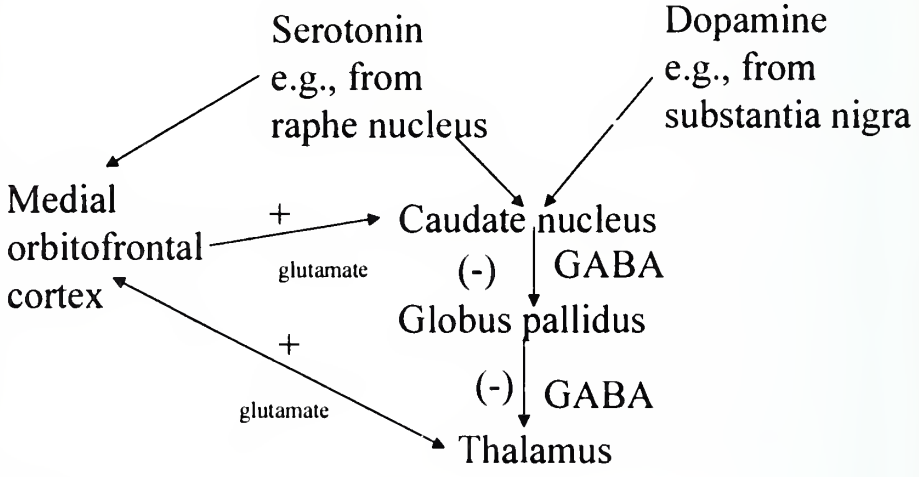

Figure 1. Proposed neuroanatomic basis of OCD.
(From Reference 14, used with permission of author.)

Conclusion

OCD following closed head injury is a rare phenomenon. It is most freqently associated with frontal and occipital head injuries, and may follow relatively mild injuries with brief periods of unconsciousness.

Disruption of the circuit involving the basal ganglion and the frontal lobes may be the pathogenic mechanism. Latency between injury and onset of symptoms is highly variable.

Obsessions with contamination and compulsive cleaning are the most frequent OCD symptoms seen in this group of patients. Psychiatric comorbidity, especially depression, is very common, and response to treatment is often poor.

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(Please contact first author for other references listed in this manuscript.)

Prasadarao B. Mukkamala, MD

Union Square • 1 Monongalia Street • Charleston, WV 25302

Dr. Mukkamala is a Diplomate of the American Board of Physical Medicine and Rehabilitation and the American Board of Electro-Diagnostic Medicine.

Specialist in Electromyography and Nerve Conduction Studies

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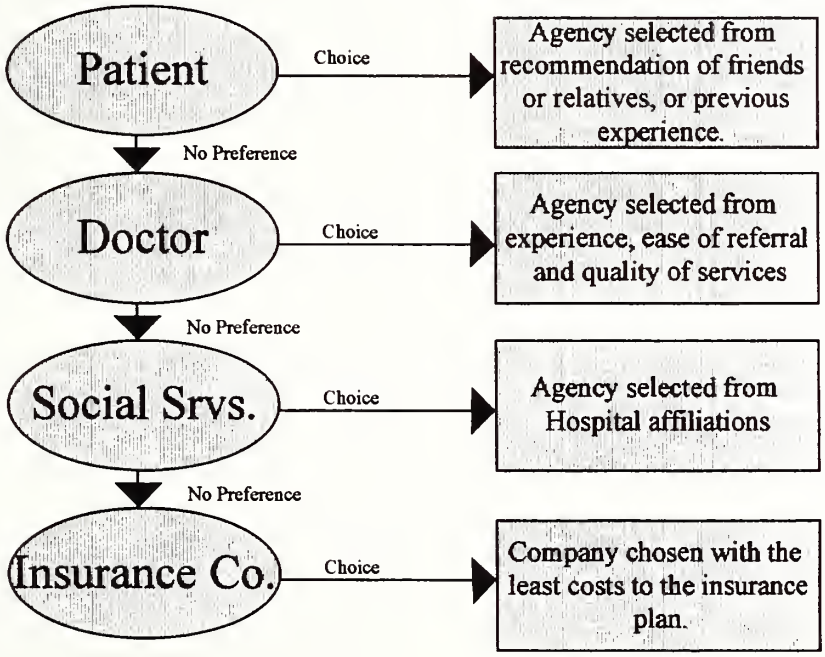

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Acute low back pain findings and management in an academic medical center

STEPHEN L. SEBERT, M.D.
Associate Professor, Department of Family Medicine, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown

JAMES E. BRICK, M.D.
Professor and Interim Chair of Medicine, Department of Medicine, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown

KATHLEEN ANDERSON, R.N., M.H.A.
Director, Medical Affairs, Ruby Memorial Hospital, Morgantown

Abstract

To compare medical records of patients treated for acute low back pain in the departments of Family Medicine, Internal Medicine, Occupational Medicine and Emergency Medicine in an academic medical center to determine if there was variation in patient population, diagnostic and treatment procedures and outcomes. Records were randomly reviewed using a standardized form for patients diagnosed with ICD 9 codes pertaining to back pain. Of the 96 patients with acute back pain seen in outpatient areas, 66 were seen by Family Medicine, 26 by Medical Group Practice (MGP), and four by Occupational Medicine. One hundred seven were seen in the Emergency Department. There was no significant difference in duration or type of pain or the type of findings or treatment. Very few had positive physical findings, (9% outpatient and 10% Emergency Department), but many more, (38% outpatient and 17% ED), had psychosocial findings (smoker, dissatisfaction with work, previous psychiatric history, psychosomatic history, or abnormal social adjustment) documented. Plain films of the lumbrosacral spine done in both practice settings did not change treatment.

Introduction

Low back pain has long been recognized as a frequent reason for medical consultation and a significant cost in terms of medical care and in loss of work. Most people have low back pain at same point in their lives. The general prevalence in the United States population is 15-20 percent (1).

Among working age people, 50% have back symptoms in any given year (2-3). Back symptoms are the most common cause of disability for persons under age 45 (4). In addition, about one percent of the United States population is chronically disabled and another one percent are temporarily disabled due to back problems (1).

Low back problems are the second leading cause of visits to primary care physicians (5); the most common reason for office visits to orthopedic surgeons, neurosurgeons and occupational medicine physicians (6); the third leading reason for surgical procedures; the fifth leading cause of hospitalizations; and cost more than $24 billion a year in medical costs alone (7). Loss of time from work as well as the disability payments for work-related low back problems can together cost up to three times as much as medical treatment. About two percent of the United States work force has compensable back problems each year. Various estimates of the total annual societal cost of back pain in the United States range from $20-$50 billion (8).

It has been widely reported that the rates for hospitalization and surgery and use of diagnostic tests for treating and assessing low back problems vary substantially among regions of the United States, as well as within small areas of individual states (9,10,11).

Methods

A chart review was conducted at Ruby Memorial Hospital in Morgantown, which is the medical center for West Virginia University, and its associated outpatient facilities to determine if there was variation in patient population and diagnostic and treatment methods between departments at an academic medical center.

A comparison was made between the way acute back pain is treated in academic programs in Family Practice (Family Medicine), and Internal Medicine (MGP). These findings were then compared with the way patients with acute back pain were treated in the Emergency Department of Ruby Memorial. ICD9 codes for back pain were used to retrieve patient record numbers for those treated in outpatient departments between January 1994 - July 1995. Fifteen hundred and seventy five patients were identified using the following ICD9 codes:

721.1	722.73	742.02
721.3	722.83	846.00
721.4	722.93	847.00
721.9	724.02	847.2
722.1	724.2	847.9
722.11	724.8	953.2
722.52	724.9	
722.52	729.2	
722.6	738.4	

The records of 100 outpatients were selected at random. Of these, 96 were found to be suitable for review. Patients with pain present more than three months were excluded. The same codes were used to identify medical record numbers of Emergency Department patients.

From January - June 1994, 1,070 Emergency Department patients were identified presenting with back pain, and 200 of these were randomly selected for review.

Of these 200, 182 were found to be suitable for review. The other 18 were miscoded diagnostically. Of the 182, 107 were found to have acute back pain of less than three months duration and 75 were found to have pain of longer than three months duration so they were excluded from the study.

The charts were then reviewed using a standardized review sheet by members of the Back Pain Practice Guidelines Committee and the review sheet results were compiled. Chi square tests were done when appropriate.

Results

Of the 96 patients with acute back pain seen in outpatient areas, 66 were seen by Family Medicine, 26 by MGP, and four by Occupational Medicine. There was no significant differences in the types of patients, pain, or findings or treatments between the departments.

Seventy-nine percent of these 96 patients with acute back pain had the pain less than two weeks, 70% had pain less than two weeks, 79% had only local pain, 17% had both radicular and local, and 3% had only radicular pain. Only 9% had positive physical findings such as weakness or decreased reflexes while 38% had positive psychosocial findings, including mention of dissatisfaction with job or marriage or unemployment or financial difficulty ($p < 0.01$ compared to Emergency Department, chi-sq.).

Eighty five percent had only one or two visits documented for their pain indicating their pain resolved after two visits. Six percent of the patients were referred for consultation with one specialist. One each was referred to one, two, three, four, five, or six separate consultants.

Nineteen percent had radiographic studies done and 13.5% had plain films done. All of these were negative except one showed slight scoliosis and one sugested osteoarthritis in the hip, none of which changed treatment. Fifty eight percent had documented follow up, 40% had no documented follow up, 21% were sent to physical therapy, 20% of the pain was work related, 15% missed work as a result of their back pain.

Of the patients seen in the Emergency Department, 107 had pain less than three months duration at the time of presentation. Of these, 88% had pain less than two weeks, 76% had only local pain, 5% had radicular pain, and 12% had both local and radicular pain. Ten percent had positive physical findings and 17% had psychosocial findings. Thirty seven percent had one or two primary care visits documented in the Emergency Department record. Nine were sent to one specialty consultant, .1% were sent to two specialty consultants. Plain films were obtained in 21% of the patients, none of which showed findings which influenced treatment.

Documentation of follow up was present in 8% of the records. The pain was work related in 26% with 7% missing work one or two days. The total number of patients who missed work due to their back pain was 19%.

Discussion

In comparing records from the Emergency Department with records from Family Medicine and MGP (Outpatient Departments), the overwhelming majority of patients seen in all places had pain lasting less than two weeks duration.

Nearly 80% percent of those seen in Outpatient Departments and in the Emergency Department had pain that was localized to the back only. Forty two percent of the Emergency Department patients had a recent history of trauma. Both Outpatient Department and Emergency Department patients had remarkably few findings on physical exam, while a higher number of patients had positive psychosocial findings.

Utilization of specialty consultants was low in both instances. There was no documentation that X-ray films changed treatment in either setting. Twenty percent of the Outpatient Department patients had work-related back pain while 26% of the Emergency Department patients had work-related back pain. Fifteen percent of the Outpatient Department patients missed work while 19% of the Emergency Department patients missed work as a result of their back pain. Only in the instance of psychosocial findings was there a difference between the outpatient area and Emergency Department.

Conclusion

There was great similarity between the patients seen in Family Medicine, Internal Medicine, and the Emergency Department in terms of duration and location of back pain. There was a striking absence of physical findings but a significant number of patients with psychosocial findings seen in both groups. Plain films of the lumbosacral spine done in both settings did not change treatment.

Both the Emergency Department and Outpatient Departments seemed to be doing a reasonably efficient job of managing patients with acute back pain from a resource utilization standpoint. However, these patients are more likely to have positive psychosocial findings than physical findings and plain films of the lumbosacral spine infrequently change treatment.

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- A symposium on the economic and medical-legal implications of the evaluation of the patient with chest pain, presented by a nationally known expert in this field.

- A luncheon panel of the "Masters of West Virginia Cardiovascular Medicine" to review the history of cardiology and cardiac surgery in West Virginia and to kick-off the 50th anniversary year of organized cardiology in America.

- Presentations by local experts, Dr. Ganpat Thackker on physician-hospital organizations and managed care in West Virginia.

- An update on fraud and abuse initiatives from HCFA by Dr. Robert Ludwig, Medical Director for Nationwide Insurance.

- CME Credits will be offered.

To culminate this day-long symposium, the Chapter is pleased to invite members of the West Virginia State Medical Association and their guests to an evening banquet highlighted by the Keynote Address by **The Honorable John D. Rockefeller, IV (D-WV)**

For more information, please contact:

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Avery to be installed as WVSMA president

"A Profession, Not a Job" is the title of the address which Parkersburg family practice physician David W. Avery, M.D., will deliver on Saturday, August 29 at The Greenbrier when he is sworn in as the WVSMA's new president. Dr. Avery's address will be presented during the Second Session of the House of Delegates at the WVSMA's 131st Annual Meeting.

Dr. Avery is a native of Syracuse, N.Y., who received his medical degree from SUNY Upstate Medical Center in Syracuse in 1979. He interned and completed a family practice residency at United Hospital Center in Clarksburg and then began practicing in Parkersburg.

Dr. Avery has been a WVSMA member since 1979 and has served as WVSMA's delegate for the AMA Young Physicians' Section, as well as an AMA delegate and alternate delegate. A member of the Legislative Committee, the Resolutions

Avery

Committee and the Annual Meeting Program Committee, Dr. Avery served as vice speaker of the House of Delegates from 1993-96, as vice president from 1996-97, and as president-elect during the past year.

In addition to his involvement with the WVSMA, Dr. Avery is the immediate past president of the West Virginia Chapter of the American Academy of Family Physicians. He also currently serves on the executive committee of the West Virginia Accountable Health Plan, the medical advisory board for PrimeOne, the Secondary Schools Activities Commission, and the Headstart Advisory Board.

During his career, Dr. Avery has served as president of the Parkersburg Academy of Medicine and of the medical staff at Camden Clark Memorial Hospital. In addition, from 1990-96, he served as chairman of the American Heart Association's Emergency Cardiac Care Committee for the Eastern Ohio Region.

Dr. Avery is board certified by the American Board of Family Practice. He and his wife, Elaine, are the parents of a son, Seth.

Crites to take office as president of Alliance

In conjunction with the WVSMA's Annual Meeting, the WVSMA Alliance will conduct its Annual Meeting August 28-29 at The Greenbrier.

WVSMAA President Kathy Fortunato will preside over the meeting, and at the conclusion of the Second Session of the WVSMAA House of Delegates AMAA President-Elect Ann Hanson, will deliver the oath of office to the new WVSMAA President Jerry Crites and other new officers. Gwen Pappas, president of the Southern Medical Association Auxiliary, and several state presidents will also be attending the convention.

Jerry majored in biology at WVU and then graduated from the

Crites

Shepard College Paramedic Program. He is currently working toward a B.A. degree in organizational leadership and development through Wheeling Jesuit University.

Jerry joined the Eastern Panhandle Alliance in 1988 and has served two terms as president. At the state level, he has served as regional director for the Northeastern Region from 1995-96; as treasurer from 1996-97; and president-elect this past year.

Jerry and his wife, Dr. Danine Rydland, are the parents of triplets - Andrew, Nicholas, and Stephen.

For a WVSMAA registration form and a schedule of events for the meeting, please turn to page 215.

Lunch & Learn programs to discuss physician extenders, computer technology in medicine

Two of the popular Lunch & Learn programs will again be presented at this year's WVSMA Annual Meeting at The Greenbrier.

The first Lunch & Learn is set for Thursday, August 27 at noon and is entitled *"Physician Extenders and the Appropriate Scope of Medicine."* The keynote facilitator for this program will be Michael Holt, director of the Physician Assistant Program at Alderson Broaddus College in Philippi.

The second Lunch & Learn will take place the following day at noon

Carpenter

and will focus on *"Computer Technology in Medicine."* Facilitating this event will be Jack Carpenter from the National Technology Transfer Center at Wheeling Jesuit University in Wheeling.

Visiting state presidents who will be attending this year's meeting will be participating in these two sessions. Both of these programs will be held in the Hayes Room and a total of 1.5 CME credits will be offered for each Lunch & Learn attended. The fee for physicians wanting CME is $50 and the fee for all other individuals is $35.

If you would like to register for the WVSMA Annual Meeting and the Lunch & Learns, you may fill out the form on page 213 or phone the WVSMA at 1-800-257-4747. Space is limited, so it is important to register as soon as possible.

See Pages 210-224 for more details about the Annual Meeting!!

Third Session at Mid-Winter Clinical Conference to focus on improving end-of-life patient care

The Third Scientific Session at this year's WVSMA Mid-Winter Clinical Conference, which will take place at the Embassy Suites in Charleston from January 21-24, will be devoted to the topic of end-of-life care.

Alvin H. Moss, director of the Center for Health Ethics and Law at West Virginia University in Morgantown, will begin the lectures on Saturday, January 23 at 1:30 p.m. with a presentation entitled *"Palliative Care: A Moral Mandate for All Physicians."* Sue Warren, M.D., F.A.C.P., medical director of Kanawha Hospice Care, Inc., will then talk about *"When is a Patient Dying: What Does the Medical Literature Say?"*

After a brief break, this session will reconvene with a lecture

Moss

Glover

Warren

entitled *"Patient-Centered Pain Management at the End-of-Life"* by Timothy Deer, M.D., D.A.B.P.M., F.A.A.D.E.P., chief executive officer of The Center for Pain Relief in Charleston. Immediately following, Jacqueline J. Glover, Ph.D., the associate director of the Center for Health Ethics at WVU, will discuss *"The Ethics of Eating, Feeding and Sedating at the End-of-Life."* The four lecturers will then join together for a case presentation/panel discussion: *"Dilaudid Did Not Touch Her Pain."*

Biographical information on these four speakers begins below and more details about this year's WVSMA's Mid-Winter Clinical Conference can be obtained by phoning the WVSMA office at (304) 925-0342.

Speakers highlighted

Dr. Moss is a practicing internist and nephrologist, who developed an interest in medical ethics as a result of his work in renal dialysis and transplantation. He is currently director of the Center for Health Ethics and Law at WVU, where he is also a professor of medicine and director of the Bioethics Program.

Dr. Moss has been a participant in the National Leadership Training Program for Physicians in Clinical Medical Ethics at the University of Chicago supported by the Pew Charitable Trusts and the Henry J. Kaiser Family Foundation. He serves as chairman of the Hospital Ethics Committee at WVU Hospitals and is the executive director of the WV Network of Ethics Committees.

A member of the Guardianship Task Force of the WV Department of Health and Human Resources, Dr. Moss chaired the committee that drafted the Health Care Surrogate Act of 1993 and the Do Not Resusitate Act. His research interests include the use of life-sustaining treatment, advance care planning, and narrative ethics.

Dr. Warren received her medical degree at Case Western Reserve University in Cleveland in 1971. After interning at Cleveland Metropolitan General Hospital, she completed a residency at North Carolina Memorial Hospital in Chapel Hill, N.C.

In 1974, Dr. Warren was named director of ambulatory medicine at CAMC, and she held this post until 1977 when she joined the faculty of the WVU/Charleston Division of the Family Practice Residency Program. She has practiced medical oncology and palliative medicine since 1979 in Charleston and currently serves as medical director of Kanawha Hospice Care, Inc.

Dr. Warren has been a clinical associate professor of family practice since 1984 at the WVU School of Medicine, and since 1990 she has also been a clinical professor of medicine at WVU. Very active in community activities, Dr. Warren has been a volunteer physician for Kanawha Hospice Care and also for West Virginia Health Right, Inc., as well as a volunteer speaker for the American Cancer Society. In addition, Dr. Warren has been a board member of Kanawha Valley Pastoral Counseling and the CAMC Civic Affairs Council.

Dr. Deer obtained his medical doctorate at the WVU School of Medicine in 1990. He then completed an internship in internal medicine and a residency in anesthesiology at the University of Virginia School of Medicine in Charlottesville.

After completing his residency in 1994, Dr. Deer remained at the University of Virginia for a clinical subspecialty fellowship in pain management at the school's Pain Management Center. He currently is the chief executive officer and a pain management physician at The Center for Pain Management in Charleston, South Charleston, Hurricane and Clarksburg. In addition, he serves a president for the Center for Pain Relief at St. Mary's in Huntington and is a member of the board of directors, a partner, and a staff anesthesiologist for Professional Anesthesia Services, Inc. in Charleston.

A clinical assistant professor at the WVU School of Medicine, Dr. Deer is a noted lecturer who has been a visiting professor at Downstate University, SUNY at Brooklyn, as well as a visiting faculty member for workshops in Memphis, Richmond and Atlanta. A fellow of the American Neuromodulation Society and the American Academy of Disability Evaluating Physicians, Dr. Deer is also a diplomate of the American Board of Pain Medicine and the American Board of Anesthesiology.

Dr. Glover received a B.A. degree in philosophy and religion from the UNC in Wilmington in 1977. She then became a research assistant at the Kennedy Institute of Ethics at Georgetown University in Washington, D.C., and began working on her Ph.D. in philosophy with a concentration in bioethics.

In 1984, Dr. Glover relocated to Chicago to teach medical humanities at the Loyola University Stritch School of Medicine. Two years later, she returned to Georgetown to complete her doctorate and join the faculty as an associate professor of health care sciences. In addition to teaching at Georgetown, Dr. Glover directed the Program in Bioethics and was a fellow in the Center for Health Policy.

In 1997, Dr. Glover accepted her present role as an associate professor of medicine and pediatrics at the Robert C. Byrd Health Sciences Center of WVU in Morgantown, where she also serves as associate director for the Center for Health Ethics and Law.

State native named president-elect of CMA

Pickett

J. C. Pickett, M.D., a native of Morgantown who is the son of the late Justus Pickett, M.D., the first chairman of the Division of Orthopedic Surgery at WVU and former chairman of the West Virginia Division of Crippled Children's Services, has been chosen as president-elect of the California Medical Association. Dr. Pickett is also the brother of George Pickett, M.D., medical director of the West Virginia Medical Institute.

Dr. Pickett, an orthopedic surgeon in private practice in Napa, is the former chief of staff and chief of surgery of the Queen of the Valley Hospital in Napa. He received his B.A. and B.S. at WVU and his M.D. from the Medical College of Virginia.

WVACS Officers

The West Virginia Chapter of the American College of Surgeons Annual Meeting was held at The Greenbrier from April 30-May 2. Officers attending the meeting were: *(First Row)* Dr. Donald Chang, councilor; Dr. Amabile Milano, past president, Ms. Sharon Bartholomew, administrator; Dr. R. C. Shah, first vp; and Dr. Eric Mantz, governor. *(Second Row)* Dr. Rigoberto Ramirez, councilor; Dr. Willis Trammell, past president; Dr. David Denning, president; Dr. Roger King, secretary/treasurer; and Dr. Sam Oliver, councilor.

Snowshoe site for psychopharmacology meeting

Psi-Med, Inc. and Thomas Memorial Hospital are sponsoring the *"1998 Mountain Retreat: Psychopharmacology & Health Care Update"* at Snowshoe Resort from October 9-11.

This meeting is designed for family practitioners, internists, psychiatrists and other physicians, psychologists, counselors, social workers, registered nurses, licensed practical nurses and physician assistants. A total of CME credits are being offered.

This conference will begin with a dinner on Friday, October 9 at 7 p.m. which will feature a lecture by Dr. Timothy Deer on *"Chronic Pain in the Elderly."* Other subjects to be discussed during the weekend will be recent advances in the diagnosis and treatment of Alzheimer's disease; normal aging issues including changes in human sexuality, utilization of health care and sleep disorders; legal topics pertaining to caregivers in relation to geriatric patients; and current health care reform.

For more information, phone (304) 744-7535 or (304) 766-3791.

Infectious disease board review course planned

The Center for Bio-Medical Communication, Inc., will hold its 3rd annual course, *"Infectious Disease '98 Board Review: A Comprehensive Review for Board Preparation"* from October 14-18 at the Ritz-Carlton Hotel in McLean, Va.

For more details about the course, phone (201) 385-8080.

Workers' Comp treating physician course offered

A free CEU course is being conducted in Charleston and in Morgantown this fall for physicians who routinely treat injured workers under the jurisdiction of the WV Workers' Compensation Division.

The course, which will take place on Saturday, Sept. 12 and Oct. 17 in Charleston and on Oct. 3 in Morgantown, details medical documentation specifics and medical management approaches to common conditions to enable initial evaluating and treating physicians to be more successful in providing care to injured workers. Priority will be given to those providers practicing in the same areas as employers enrolled in the Coordinated Care Project. In addition to this training, those providers treating workers from the Coordinated Care Project employers will receive generalized treatment feedback and course reinforcement based on the particular nature of a worker's injury.

Phone Bill Murray at (304) 293-0406 for an application form or e-mail Dr. Ed Doyle, project co-investigator at edoyle@wvu.edu.

Deepak Chopra to speak in Huntington

The Marshall University School of Medicine is presenting noted author and speaker Deepak Chopra, M.D., C.A., on Sunday, October 25 at 2 p.m. in the Huntington Civic Arena for a lecture entitled *"Principles & Importance of Wellness."*

CME and CNU credits are being offered for this lecture which is open to the general public. For more CME and CNU details, phone Glenna Altizer at (304) 526-2285, and general admission tickets can be purchased through Ticketmaster beginning Monday, September 7.

For more information, contact Dr. Tara Sharma at (304) 523-0384 or Linda Holmes at (304) 691-1711.

131st Annual Meeting Preliminary Program

Pre-Convention Meetings

Tuesday August 25, 1998

6 p.m.	Executive Committee Meeting, Thomas H. Chang, MD, President, presiding, Pierce Room
7:30 p.m.	Executive Committee Dinner, Tyler Room

Wednesday August 26, 1998

8 a.m. - Noon	Exhibit setup, Exhibit Center
9 a.m.	WVSMA Council Meeting, Ronald E. Cordell MD, Chairman, presiding, McKinley Room
11:30 a.m.	Executive Committee/Council - Component Society and Specialty Society Presidents' Luncheon, Chesapeake Bay
Noon - 4:30 p.m.	Registration, Exhibit Center Foyer
1 - 4:30 p.m.	Exhibit Visitation
12:30 - 1:30 p.m.	Delegate Registration, Governor's Hall

Convention Program

Wednesday, August 26

1:30 - 4:30 p.m. **First Session House of Delegates, Governor's Hall**

John D. Holloway, MD, Speaker of the House and Stephen L. Sebert, MD, Vice Speaker, presiding

Welcome

Thomas H. Chang, MD, FACS, WVSMA President

Introductions & Recognitions:

Visiting State Presidents

1998 Annual Meeting Program Committee

WVSMAA President, Mrs. Kathy Fortunato

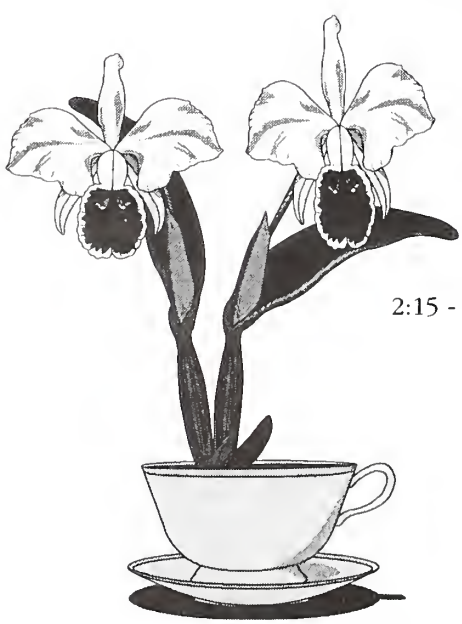
1998 WVSMA Award Presentations:

"Rural Health Physician of the Year" Award

Presidential Citation

Wyeth-Ayerst Physician Award for Community Service

AMA-ERF Awards



Introduction of AMA President- Nancy W. Dickey, MD

AMA President's Address, *"Our AMA: A Leader in Professionalism, the Delivery System, and Medical Ethics"*

Nancy W. Dickey, MD, 1998-1999 AMA President

2:15 - 2:30 p.m. **Break**

Thomas L. Harris Address

"Anyone Can Treat Cardiac Arrhythmia," Alden H. Harken, MD

Constitution and By-Laws Committee Report

Harry S. Shannon, MD, Chairman

Nomination Committee Report, Dennis M. Burton, Chairman

Resolutions Committee Report
David W. Avery, MD, Chairman

WVSMA Presidential Address, Thomas H. Chang, MD, FACS
1997-1998 WVSMA President

5 p.m.	Adjournment
6:30 - 7:30 p.m.	Presidential Reception, *Hosted by Harrison County Medical Society,* Chesapeake Bay and Terrace

Thursday, August 27, 1998

7 - 8:30 a.m.	Medical Education Committee Business Breakfast, James D. Helsley, MD, presiding, Pierce Room
8:30- 3 p.m.	WVSMA/Alliance Registration, Exhibit Center Foyer
8:30- 2 p.m.	Exhibit Visitation, Exhibit Center
8:30 - Noon	**FIRST GENERAL SESSION, Governor's Hall,** Thomas H. Chang, MD, FACS, Moderator
8:30 - 9:15 a.m.	*"Lung Reduction,"* Robert J. Keenan, MD
9:15 - 10 a.m.	*"Diabetes Care in the New Millennium: Will you be an Evangelist or an Ostrich?"* Frank L. Schwartz, MD, FACE
10 - 10:15 a.m.	Refreshment Break
10:15 - 11 a.m.	*"Genes Don't Count,"* Alden H. Harken, MD
11 - 11:45 a.m.	*"Congestive Failure 1998,"* David L. Pearle, MD
11:45 - Noon	Panel - Questions and Answers
Noon	**Lunch & Learn** *"Physician Extenders and Appropriate Scope of Practice"* Michael Holt, Director, PA Program and Visiting Dignitaries Hayes Room
1:30 p.m.	Committee on Resolutions, David W. Avery, MD, presiding, Open/Closed Session, West Virginia Room
1:30 - 4:30 p.m.	Medical Assurance of West Virginia Inc., McKinley Room, Physician Advisory Board Meeting - Members Only
2 p.m.	Golf, Tennis, and Volleyball Tournaments Golf Chairman, Jeffrey A. Stead, MD *Courtesy of Oasis Pain Management,* *"Hole-in-One" on Hole #3, Sponsored by RMI, Inc.* Tennis Chairman, William A. Scaring, MD, *Courtesy of Acordia of WV* Volleyball Co-Chairmen, James L. Comerci, MD, Ronald D. Stollings, MD *Courtesy of Novartis Pharmaceuticals*
3 - 5 p.m.	WESPAC Meeting, Pierce Room
6:30 - 7:30 p.m.	Reception, *Hosted by Medical Assurance of WV and Acordia of WV* Colonial Lounge and Terrace

Friday, August 28, 1998

7 - 8:30 a.m.	WVSMA Section on Surgery Scientific/Business Breakfast, Daniel S. Foster, MD, presiding, Chesapeake Bay
8 - 9 a.m.	Alliance Executive Committee Meeting, Main Dining Room
8:30 - 9:30 a.m.	Alliance Registration, Filmore Room
8:30 - 4:30 p.m.	WVSMA Registration, Exhibit Center Foyer
9 - Noon	**SECOND GENERAL SESSION, Governor's Hall,** James D. Helsley, MD, Moderator Welcome, Thomas H. Chang, MD, FACS, President
9 - 9:45 a.m.	*"Beyond Medical School: Managed Care's Impact on Education,"* Robert M. D'Alessandri, MD

9:45 - 10:30 a.m.	*"The Role of State Medical Societies in the Evolving Climate of CME as We Approach the New Millennium,"* Albert N. May, MD
:30 - 10:45 a.m.	Refreshment Break, Presentation of Trophies and Door Prizes
10:45- 11:30 a.m.	*"Continuing Medical Education and State Licensure,"* Gerald J. Bechamps, MD
11:30 - Noon	Questions & Answers Session
Noon	**Lunch & Learn**
	"Computer Technology in Medicine," Mr. Jack Carpenter, National Technology Transfer Center - NASA, Hayes Room
Noon - 4 p.m.	WV Psychiatric Association Meeting, Pam Sullivan, MD, presiding, West Virgina Room
Noon - 2 p.m.	WVMI Board of Trustees Meeting, Mabel M. Stevenson, M.D., presiding, McKinley Room
Noon	Alliance Board Luncheon, Fundraiser and Styleshow, Filmore Room
2 - 5 p.m.	Medical Assurance Loss Control Seminar, Eisenhower A
4:30 - 5:30 p.m.	1999 Scientific & Educational Sessions Committee, James L. Comerci, MD, presiding, Lee Room
4:30 p.m.	Marshall Alumni Board Meeting, Washington Room
6 - 7 p.m.	Reception, *Hosted by West Virginia University and Marshall University Schools of Medicine* Cameo Ballroom
9 - Midnight	Entertainment, *Vito DiSalva and WE THREE*, Chesapeake Room

Saturday, August 29

7 -8 a.m.	Kanawha County Caucus Breakfast, Frank Trupo, MD, presiding, Drapers Cafe
7:30 - 8:30 a.m.	American Academy of Family Physicians, Linda Savory, MD, presiding, Draper's Cafe
7:30 - 8:30 a.m.	Breakfast Meeting, Brooke, Hancock, Marshall, Ohio Counties, Northern Panhandle, William E. Noble, M.D., presiding, Main Dining Room
7:30 - 11 a.m.	WV Radiological Society Meeting, Fred Gabriele, MD, presiding, Lee Room
8 - 9 a.m.	Delegate Voting Registration, Chesapeake Hall Foyer
8 a.m.	Alliance Past President's Breakfast, Washington/Lee Rooms
9:15 a.m.	**WVSMA Second Session House of Delegates, Chesapeake Hall**
	Presentation of Colors
	Reaffirmation
	Necrology Report
	Welcome, Thomas H. Chang, MD, FACS, President
	Introduction of 1998-99 WVSMA Alliance President, Mr. Jerry Crites
	Edmund B. Flink Address
	"1948-1998: A Retrospective," Robert J. Marshall, MD, MACS
	Business Meeting
	Election of Officers
	Constitution and By Laws Committee Report, Harry S. Shannon, MD, Chairman
	WVSMA Resolutions Committee Report, David W. Avery, MD
	Announcement of Election Results
Noon	WVSMA Past Presidents, Visiting State Presidents and 50-Year Graduates Luncheon, Hayes Room
1 p.m.	**Reconvene Second Session of the House of Delegates**
	Installation of Officers
	Oath of Office
	Presidential Address: *"A Profession, Not a Job,"* David W. Avery, MD, Parkersburg, WV
	Adjournment

- An AMA Delegation Meeting in WVSMA Suite #6613 will follow the 2nd Session of the House of Delegates.

TBA	Reception Honoring Newly Installed Officers of WVSMA and Alliance, *Hosted by Parkersburg Academy of Medicine* Colonial Lounge & Terrace

The West Virginia State Medical Association

131st Annual Meeting

August 26-29, 1998

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Fax us your application! (304) 925-0345.

Request an e-mail registration form! Visit our website at www.wvsma.com. Complete our Guestbook and request a registration form!

Cancellation of registration should be in writing. If a cancellation is postmarked or phoned to the WVSMA before August 1, 1998, the paid registration fee will be refunded less a $50 administrative charge. For written or phoned cancellations after August 1, 1998, no refunds will be made.

Registration Fees — After August 1, 1998

❒ WVSMA Member	$125
❒ Non-member	$175

Lunch & Learn — Thursday, August 27, 1998
" Physician Extenders and Appropriate Scope of Medicine"

❒ WVSMA Member	$50 (each session)
❒ All others	$35 (each session)

Lunch & Learn — Friday, August 28, 1998
"Computer Technology in Medicine"

❒ WVSMA Member	$50 (each session)
❒ All others	$35 (each session)

Total Due: _____

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WVSMA Alliance Preliminary Program

Wednesday, August 26

Noon - 4:30 p.m.	Registration, *Exhibit Center Foyer*
1:30 p.m.	Introduction of WVSMAA President, Kathy Fortunato, *Governor's Hall*
1:45 p.m.	Introduction of AMA President, Nancy W. Dickey, M.D., *Governor's Hall*
3:45 p.m.	WVSMA Presidential Address, Thomas H. Chang, M.D., *Governor's Hall*
6:30 p.m. - 7:30 p.m.	Presidential Reception, Hosted by Harrison County Medical Society *Chesapeake Bay and Terrace*

Thursday, August 27

8:30 a.m. - 3 p.m.	Registration, *Exhibit Center Foyer*
Noon	Lunch & Learn, "Physician Extenders and Appropriate Scope of Practice," *Hayes Room*
2 p.m.	Golf, Tennis and Volleyball Tournaments, *See WVSMA Registration Table for locations*
6:30 p.m. - 7:30 p.m.	Reception, Hosted by Acordia of WV and Medical Assurance of WV, *Colonial Lounge and Terrace*

Friday, August 28

8:30 a.m. - 9:30 p.m.	Registration, *Outside Filmore Room*
8 a.m. - 9 a.m.	Executive Committee Meeting, *Main Dining Room*
9:15 a.m.	**First Session House of Delegates,** *Kathy Fortunato, presiding, Filmore Room*
Noon	**President's Board Luncheon,** Styleshow and AMA Foundation Fundraiser, *there will be a $25 fee for this event*
2 p.m.	**Second House of Delegates,** *Kathy Fortunato, presiding, Filmore Room*
6 p.m. - 7 p.m.	Reception, Hosted by WVU and MU Schools of Medicine, *Cameo Ballroom*
8 p.m. - 9 p.m.	Viewing and Auction, fundraier for AMA Foundation, *Chesapeake Hall*
9 p.m.	Entertainment, Vito DiSalva and WE THREE, *Chesapeake Hall*

Saturday, August 29

8:15 a.m.	Past President's Breakfast (Invitation Only), *Washington and Lee Room*
8:30 a.m. - 9:30 a.m.	Registration, *Outside Filmore Room*
9:45 a.m.	Post-Board Meeting, *Jerry Crites, WVSMAA President presiding*
Noon	Buffet-Style Luncheon (Fee charged)
1 p.m.	Installation of WVSMA Officers, *Chesapeake Hall*
1:30 p.m.	WVSMA Presidential Address, *David W. Avery, M.D.*
TBA	Reception honoring newly installed Officers of WVSMA and Alliance Hosted by Parkersburg Academy of Medicine, *Colonial Lounge and Terrace*

1998 WVSMAA ANNUAL MEETING - REGISTRATION FORM

Name _____

Address _____

City, State, Zip _____ Phone Number _____

Please list county, state offices you've previously held _____

☐ **My $5 registration fee, cash or check, made payable to the WVSMAA, is enclosed.**

MAIL TO: Christina Dixon, WVSMAA, PO Box 4106, Charleston, WV 25364

Although you can register on-site, name tags will only be pre-printed for those who pre-register.
For more information, call Christina at (800) 257-4747.

Don't Wait...Register NOW to

Lunch & Learn

Join us at The Greenbrier for our popular Lunch & Learn programs beginning Thursday, August 27 at noon with Mr. Michael Holt, director of the Physician Assistant program at Alderson Broaddus College. He will discuss *"Physician Extenders and the Appropriate Scope of Medicine."*

The second Lunch & Learn, Friday, August 28 at noon, will feature Mr. Jack Carpenter, from the National Technology Transfer Center, NASA, speaking about *"Computer Technology in Medicine."*

Both programs will be held in the Hayes Room and the cost for physicians is $35 and $50 for all others. 1.5 CME credits will be offered for EACH Lunch & Learn program attended.

Space is limited, so it is important to register NOW if you plan to attend either of these informative sessions. To register for either or both of the programs, please call (800) 257-4747.

The West Virginia State Medical Association presents

DiSalvo & We Three

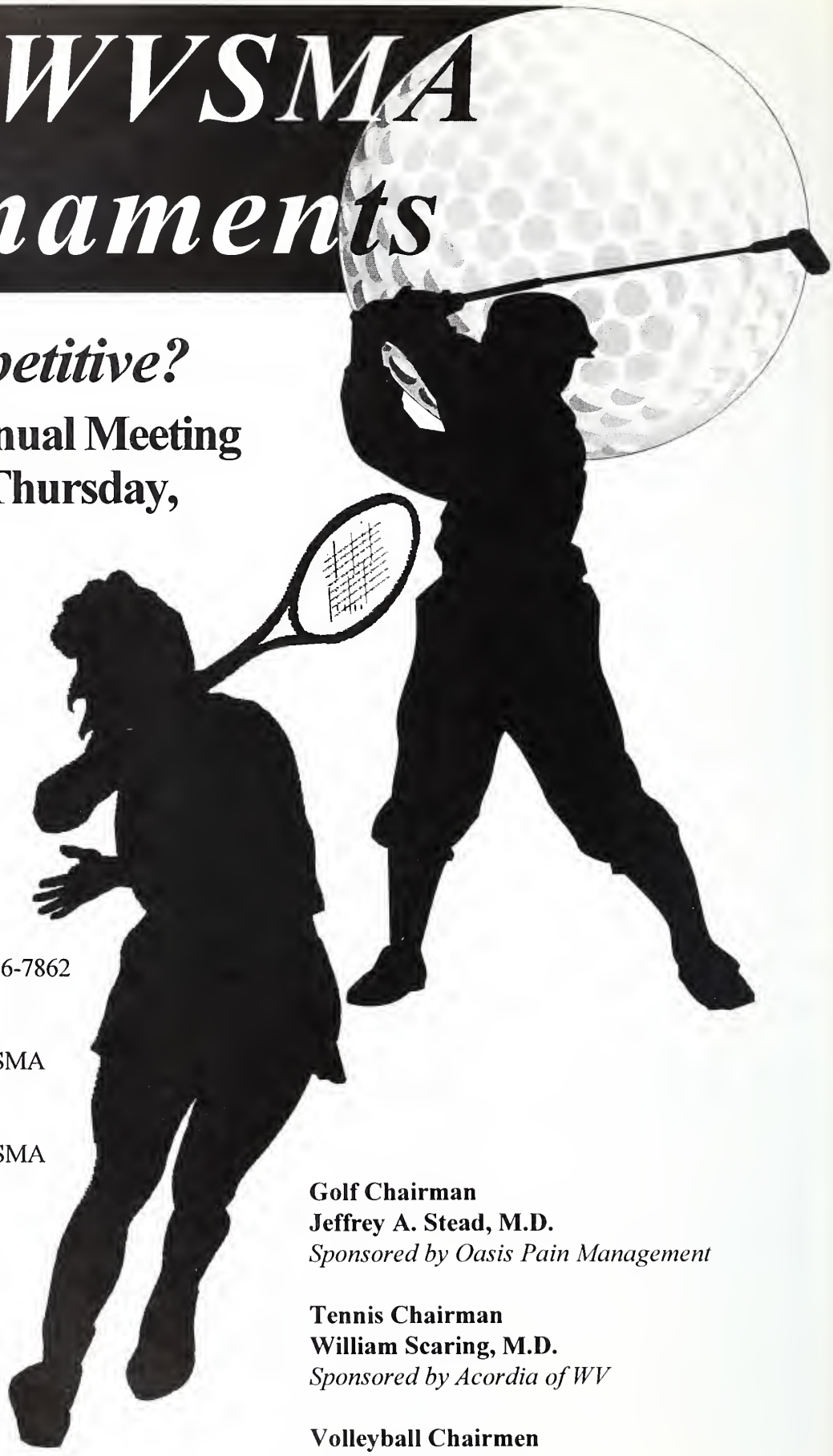
Join us for a wonderful, relaxing evening of music at The Greenbrier, Friday, August 28 from 9 p.m. to Midnight.

DiSalvo & WE THREE promises to mesmerize the crowd with their variety of music, with styles ranging from Classical Jazz, to the Swing Era of the 50s, to Italian Folk and popular music of the 90s.

This five member band, formed in 1965, is well-known around the country, having just recorded their fifth album.

Plan to attend this exciting evening of music and dancing. The band will begin at 9 p.m. in the Chesapeake Hall immediately following dinner in the main dining room. Although there will be no cost for the event, donations will be accepted for the AMA-Education and Research Foundation.

1998 WVSMA Tournaments



Feeling Competitive?

Join us for the Annual Meeting Tournaments on Thursday, August 27!

To Register for:

- **Golf** — Please call (304) 536-7862 for tee times.
- **Tennis** — Sign up at the WVSMA Registration Desk
- **Volleyball** — Sign up at the WVSMA Registration Desk

Golf Chairman
Jeffrey A. Stead, M.D.
Sponsored by Oasis Pain Management

Tennis Chairman
William Scaring, M.D.
Sponsored by Acordia of WV

Volleyball Chairmen
Ron D. Stollings, M.D.
James L. Comerci, M.D.
Sponsored by Novartis Pharmaceuticals

For more information, please call Christina at the WVSMA, (304) 925-0342.

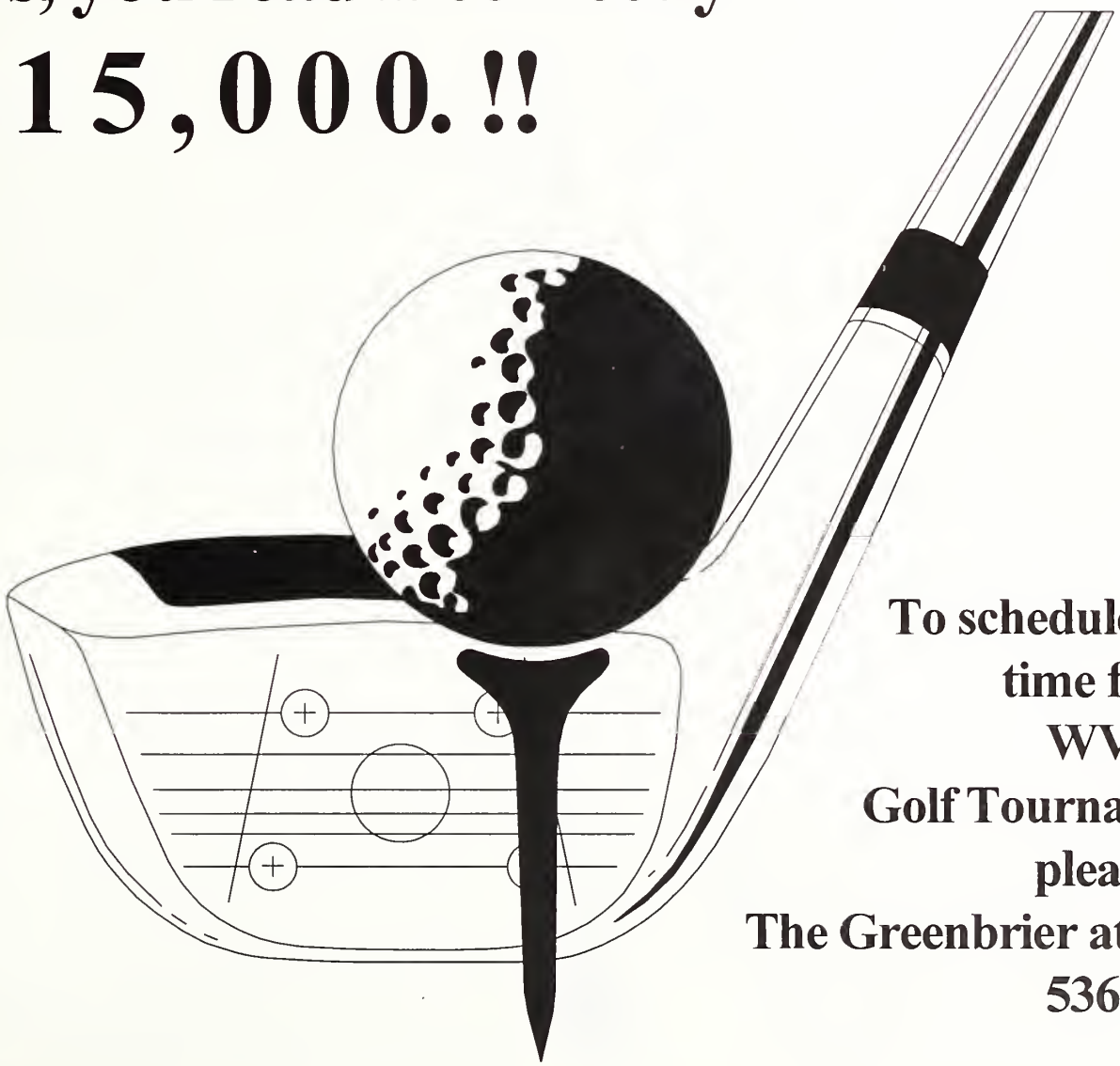
If you don't play golf, you might want to start!

RMI, Ltd. is sponsoring a "Hole-In-One" on Hole #3 of the "Old White" course. The contest is being held in conjunction with the WVSMA Golf Tournament, sponsored by Oasis Pain Management, Thursday, August 27 from Noon - 2 p.m.

The prize is Fifteen Thousand Dollars...

yes, you read it correctly-

$15,000.!!

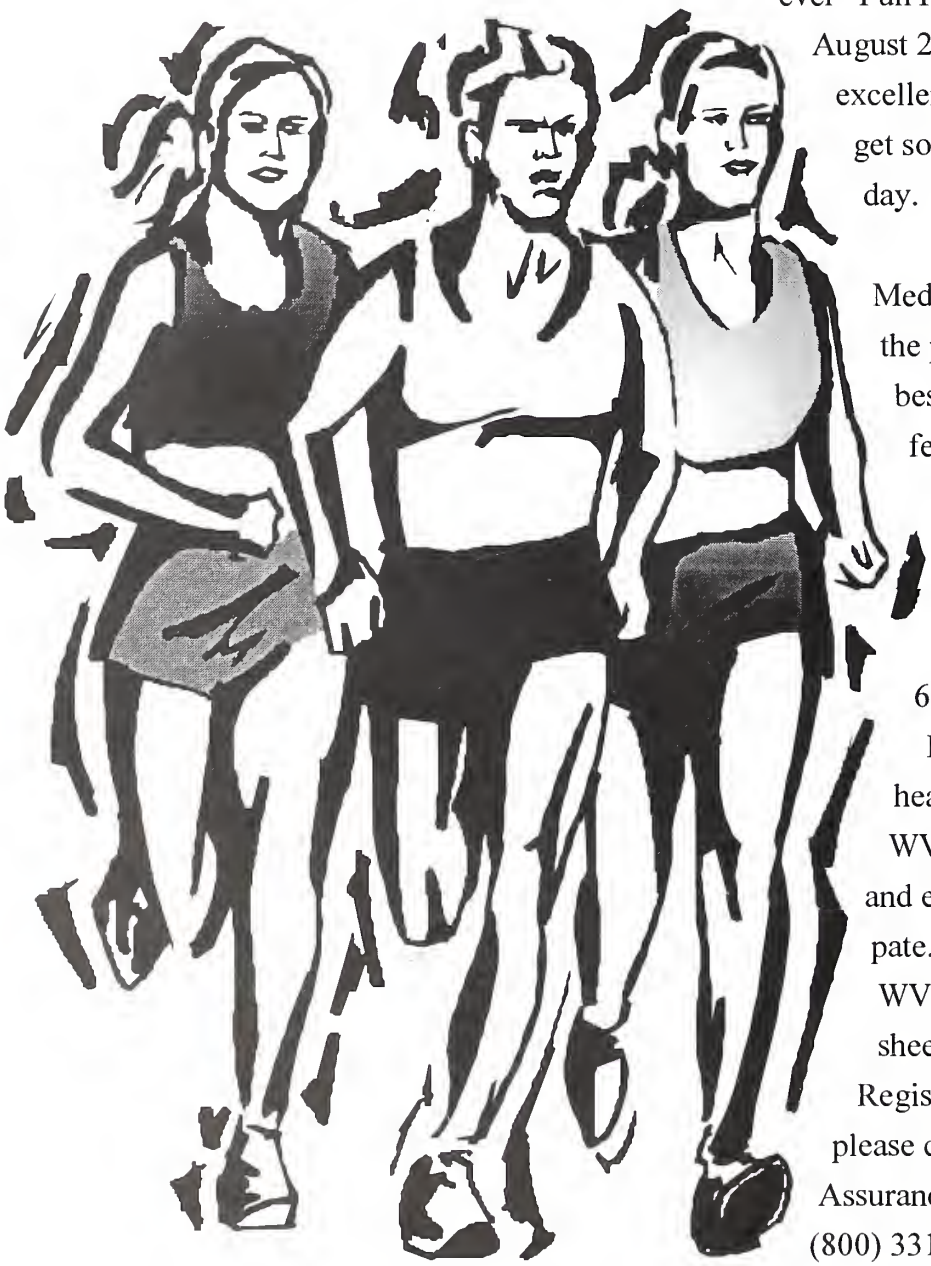


To schedule a tee time for the WVSMA Golf Tournament, please call The Greenbrier at (304) 536-7862.

Join us at The Greenbrier
Saturday, August 29 at 7 a.m. for a

"Fun Run-Walk"

Hosted by Medical Assurance of West Virginia



As part of the West Virginia State Medical Association's 131st Annual Meeting at The Greenbrier, August 26-29, Medical Assurance is hosting its first ever "Fun Run-Walk" Saturday, August 29 at 7 a.m. The 2-mile run/walk is an excellent way to work off some calories and get some exercise before you start your day.

Medical Assurance will provide hats to all the participants and will offer prizes for best dressed, best "hat hair," fastest female, fastest male, best dressed, oldest participants and other flattering categories! Fruit, granola bars, coffee, fruit juices and water will be served starting at 6:30 a.m.

Plan now to attend this fun and healthy event at The Greenbrier. All WVSMA members, spouses, children, and exhibitors are encouraged to participate. Look for more information in the WVSMA Preliminary Program. Sign up sheets will be located at the WVSMA Registration Desk. For more information, please call Kathi Burton at Medical Assurance, (304) 522-0601 or (800) 331-6298, fax (304) 522-0602

WVSMA Annual Meeting Delegates & Alternates

BOONE (2) - ***DELEGATES:*** - Ron D. Stollings, Robert B. Atkins

BROOKE (2) - ***DELEGATES:*** Patsy P. Cipoletti Jr., Joseph J. DePetro III
ALTERNATES: Leticia Velarde, Rogelio L. Velarde

CABELL (12) - ***DELEGATES:*** Michael E. Kilkenney, Jeffrey L. Leaberry, Joseph A. Locascio III, R. Arturo Roa, Phillip R. Stevens, Marc A. Subik

CENTRAL WV (4) - ***DELEGATES:*** Arnold F. Gruspe, Rigoberto R. Ramirez
ALTERNATES: Joseph B. Reed, Arturo B. Sabio

EASTERN PANHANDLE (5) - ***DELEGATES:*** Edward F. Arnett, Daryl M. LaRusso, Danine A. Rydland, Jack F. Shamblin

FAYETTE (3) - ***DELEGATES:*** Joe N. Jarrett
ALTERNATES: Enrique Aguilar

GREENBRIER VALLEY (4) - ***DELEGATES:*** Manuel A. Gomez, Alan Lee, Robert Scott, Stephan R. Thilen

HANCOCK (4) - ***DELEGATES:*** Antonio S. Licata, Gurdev S. Purewal

HARRISON (5) - ***DELEGATES:*** Cordell A. De La Pena, Douglas E. McKinney
ALTERNATES: John A. Bellotte, Erlinda L. De La Pena

KANAWHA (19) - ***DELEGATES:*** Bipin H. Avashia, Nicholas Cassis, Ronald E. Cordell, W. Alva Deardorff, Michael O. Fidler, Albert F. Heck, Tony C. Majestro, Jimmie L. Mangus, Lee L. Neilan, R. Sam Oliver, David M. Ritchie, Elizabeth L. Spangler
ALTERNATES: Moutassem B. Ayoubi, Gina R. Busch, Sandra Y. Elliott, E. Reed Heywood, Mohammad Z. Khan, Chandra M. Kumar, Reginald J. McClung, Samuel S. Newman, Joseph T. Skaggs, Robert E. Stone, Edward H. Tiley III

LOGAN (3) - ***DELEGATES:*** Joby Joseph, Raymond O. Rushden, Ramanathan Padmanaban
ALTERNATES: Suthipan Chevy, Subramaniam N. Subramaniam

MARION (5) - Names not submitted

MARSHALL (2) - Names not submitted

MASON (2) - ***DELEGATES:*** Suresh K. Agrawal, John A. Wade Jr.,
ALTERNATES: Randall F. Hawkins, Clyde J. Rorrer

MCDOWELL (2) - Names not submitted

MERCER (5) - Gereroso D. Duremdes

MONONGALIA (20) - ***DELEGATES:*** Mary Ann Sens, Jeffrey A. Stead

OHIO (10) - ***DELEGATES:*** James L. Comerci, Terry L. Elliott, Michael A. Fortunato, Barton K. Hershfield, Derrick L. Latos, William E. Noble, Geoffrey L. Ruben
ALTERNATES: Dennis L. Burech, Rodney L. Curtis II

PARKERSBURG ACADEMY (8) - Names not submitted

POTOMAC VALLEY (2) - Names not submitted

PRESTON (2) - ***DELEGATES:*** Max A. Harned, John J. Keefe

PUTNAM (2) - Names not submitted

RALEIGH (7) - ***DELEGATES:*** C. Richard Daniel Jr., Ahmed D. Faheem, Wallace D. Johnson, Carl S. Larson, Carlos E. Lucero, Rajnikant C. Shah, William A. Scaring
ALTERNATES: Anthony T. Dinh, Prospero B. Gogo, Worthy W. McKinney, Husam M. Nazer, Robert P. Pulliam, Norman W. Taylor, Nancy R. Webb

SOUTH BRANCH VALLEY (2) - ***DELEGATES:*** Bruce W. Leslie, Anil K. Makani
ALTERNATES: Larry C. Rogers

TUG VALLEY (2) - Names not submitted

TYGARTS VALLEY (4) - ***DELEGATES:*** Serge Cormier, Stanley S. Masilamani, Joseph A. Tavolacci , Christopher Z. Villaraza
ALTERNATES: Alan W. Cashell, Domingo T. Chua, Joseph A. Noronha, Joung W. Rhee

WESTERN (2) - Names not submitted

WETZEL (2) - Names not submitted

WYOMING (2) - Names not submitted

WVSMA Annual Meeting Exhibitors

BOOTH #1
Acordia of West Virginia, Inc.
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BOOTH #2
Family Medicine Foundation of WV
Chris Ferrell

BOOTH #3
Abbott Laboratories

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WV Rural Health Education Partnerships
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Kim McCourt, Heidi Metheny and Joe Antonini

BOOTH #32
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Beverly Howard

BOOTH #34
Pfizer Roerig

BOOTH #35
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David Averion and Lisa Averion

BOOTH #36
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BOOTH #37
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Jim Strawn and Kay Stewart

BOOTH #38
WV Bureau for Public Health, Office of Maternal and Child Health

BOOTH #39
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Lt. Yvonne Williams

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BOOTH #45
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BOOTH #46
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Marlon Gutierrez

BOOTH #47
SmithKline Beecham
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Sahar Al-Shallah, Penny Powell and Nanette Tilton

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Staff Sergeant Pamela Wincapaw

BOOTH #55
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Linda Holmes and Beth Hammers

BOOTH #56 & #57
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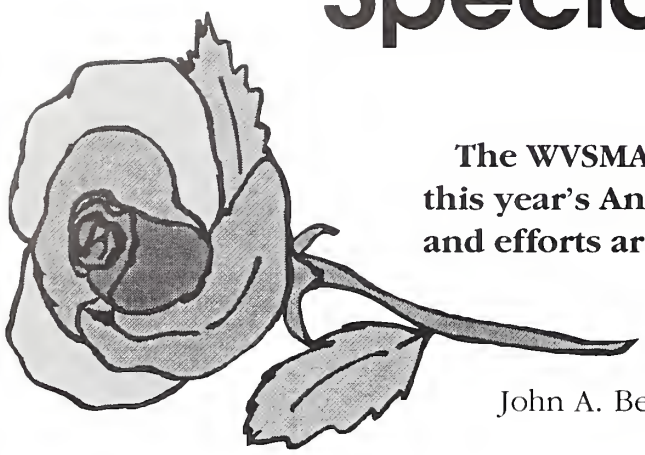
Exhibits are an integral part of the Annual Meeting and become a valuable adjunct to the scientific program. The income from rental of exhibit space enhances our budget and allows us to offer you a top-notch, professional meeting, including the ability to attract a number of well-known speakers.

So, please take time to visit each exhibit booth and talk with the representatives about the products, services or programs their companies, schools and organizations have to offer you.

Special Thanks!



The WVSMA staff would like to recognize the members of this year's Annual Meeting Program Committee. Your time and efforts are greatly appreciated!

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Mabel M. Stevenson, M.D.

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CME - Marshall University

Kari Long
CME - WVU, Morgantown

Robin Rector
CME - WVU, Charleston

The WVSMA staff would also like to recognize the following firms, associations and schools for contributing support and educational grants for this year's Annual Meeting:

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West Virginia University School of Medicine

Mid-Winter Clinical Conference

Embassy Suites, Charleston, W.Va.

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WVSMA is announcing its FIRST Mid-Winter Clinical Conference at the NEW EMBASSY SUITES!

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CME & Special Events

Camcare Health Education & Research Institute

"Fundamentals of Critical Care Support"
Aug. 29-30, Camcare Health Education & Research Institute, Charleston

"Update in General Surgery"
Sept. 2, 12:30 p.m., Robert Cochran, M.D., Montgomery General Hospital, Montgomery

"Organ Procurement"
Sept. 2, 6:30 p.m., Lawrence Wyner, M.D., Fayette County Medical Society, Plateau Medical Center, Oak Hill

"Advanced Cardiac Life Support Provider Course"
Sept. 10-11, 8 a.m., Robert C. Byrd HSC of WVU, Charleston Division

"Alternative Therapies"
Friday, Sept. 11 & Tuesday, Nov. 24, Camcare Health Education and Research Institute, Charleston

"Food Borne Diseases"
Sept. 11, noon, Donald Rosenburg, M.D., Logan General Hospital, Logan

"Current Issues in Cancer"
Sept. 15, 6:30 p.m., James Frame, M.D., Roane General Hospital, Spencer

"Wound Care Management"
Sept. 16, 6 p.m., Scott Spradlin, D.O., Man Appalachian Regional Hospital, Man

"13th Annual Trauma Conference"
Sept. 18, 8 a.m., Tamarack, Beckley

"Issues in Medical Ethics" (four 2-hour sessions)
Sept. 22 & Oct. 6 & Oct. 27 & Nov. 3 (5 p.m. - 7 p.m.) Camcare Health Education & Research Institute, Chas.

Huntington Medical Community Foundation

"Industrial Hearing Loss"
Sept. 9, 6 p.m., Joseph B. Touma, M.D., Tug Valley Medical Society, The Brass Tree Restaurant, Williamson

"Rural Health Care for the Elderly"
Sept. 10, noon, Robert Walker, M.D., Our Lady of Bellefonte Hospital, Ashland

"Occupational Medicine Conference"
"Occupational Lung Disease" - James Becker, M.D. *&*
"Lower Back Pain" - Rabah Boukhemis, M.D., Sept. 12, The Brass Tree Restaurant, Williamson, 8:15 a.m. & noon

"Ethical Dimensions of Health Care" - Hoyt Burdick, M.D.
"What Physicians Need to Know About Advanced Directives" - Sept. 16 , 6 p.m. & 8 p.m., Paul English Smith, M.D., Williamson Memorial Hospital, Williamson

"Personality Disorders"
Sept. 24, noon, Dan Cowell, M.D., Pleasant Valley Hospital, Point Pleasant

Marshall University School of Medicine

"ALL: The Most Common Cancer of Childhood"
Aug. 30, 6 p.m., Andrew Pendleton, M.D., Three Rivers Medical Center, Louisa, Ky.

"8th Annual Cancer Conference"
Sept. 18, 8 a.m., St. Mary's Hospital, Room 2109

"4th Pediatric Critical Care Conference"
Oct. 3, 8 a.m., J. Michael Waldeck, M.D., Cabell Huntington Hospital Auditorium

Robert C. Byrd HSC - Morgantown

"Workers' Comp: WV Statute and M.D. Obligations"
Sept. 10, 7 p.m., Edward Doyle, M.D. Wetzel County Hospital, New Martinsville

"Sports Medicine Office Practice Pearls"
Sept. 16, 1 p.m., William Post, M.D., Fairmont Clinic, Fairmont

"Diabetic Nephropathy"
Sept. 16, 6 p.m., Rebecca Schmidt, D.O., United Hospital Center, Clarksburg

"The Multidisciplinary Approach to Lung Cancer"
Sept. 18, 7 p.m., Drs. John Rogers, Geoffrey Graeber, John Frich, Janis Hurst and Naresh Gupta, Garrett County Memorial Hospital, Oakland, Md.

"Key Elements of the Sports Physical"
Sept. 24, 7:10 a.m., Matt Lively, M.D., St. Joseph's Hospital, Parkersburg

West Virginia State Medical Association

"WVSMA's Annual Meeting"
Aug. 26-29, The Greenbrier, White Sulphur Springs

WVSMA's Mid-Winter Clinical Conference"
Jan. 21-24, Embassy Suites, Charleston

Ode to the Brown Recluse

(This poem was written by J.D. Hathaway, who is a patient of Dr. Hugh Lindsay of Morgantown.)

They say that most arachnids
Are really quite benign;
They're beneficial don't you know,
Eating insects all the time.

But one kind in particular
Proves this is a ruse;
I'm speaking of that spider fiend
The dreaded Brown Recluse.

The Brown Recluse is nasty,
A most unfriendly sort;
She'll move into your living space
Then bite you just for sport.

Her fangs are full of venom
A highly toxic brew;
It aids her in digestion
When she makes a meal of you.

I was cleaning out the closet
When that spider brought me woe;
She crawled along the baseboard
And bit me on the toe.

It started as a blister
And soon began to swell,
My toe got blue and cratered
And hurt like holy hell.

The doctor said he wasn't sure
A spider caused the wheal,
But I'm convinced she did because
It took two months to heal.

The Brown Recluse is on the loose
It really makes me fret;
I've put out glue traps everywhere,
But I haven't caught her yet.

One day she'll come to visit you
You'd really best beware;
I hope she'll not be hiding out
Inside your underwear.

J. D. Hathaway

Bureau for Public Health News

This page of material is submitted and paid for by the Bureau for Public Health.

West Virginia Cancer Registry recognized

The West Virginia Cancer Registry (WVCR) located within the Division of Surveillance and Disease Control was recognized for excellence in data collection in April by the North American Association of Central Cancer Registries (NAACCR).

The WVCR was one of 36 cancer registries in the U.S. and Canada who submitted 1995 cancer data, excluding patient identifying data, to NAACCR for evaluation of completeness, quality, and timeliness. This was the first time a certification process has been available for population-based registries in North America.

NAACCR identified the following objectives for this certification process: to establish objective criteria for recognizing population-based cancer registries which have achieved excellence in the areas of completeness, quality, and timeliness; and to provide confidential feedback which registries can use both to target their current resources, and to argue for necessary additional resources.

The WVCR was recognized for meeting the "gold standard" in the following registry elements:

(1) Completeness of information recorded for each case of cancer;
(2) Completeness of follow-back on cases identified from death certificates;
(3) 100% of data passing a computer edits program developed by the National Program of Cancer Registries, Centers for Disease Control and Prevention; and
(4) timeliness of data collection.

The WVCR met the "silver standard" for completeness of case ascertainment by entering 91% of the expected number of cases newly diagnosed in 1995. The expected number is based on the U.S. incidence/mortality rate ratio applied to the actual West Virginia mortality rates in 1995.

During the next year, more effort will be made to inform health care providers of cancer reporting requirements in West Virginia. Any patient with a diagnosis of cancer, with the exception of basal cell and squamous cell carcinomas of the skin, not admitted to a hospital within West Virginia must be reported by the physician. In the changing health care system, an increasing number of cancer cases are being diagnosed and treated outside the traditional hospital setting. This is especially true for certain cancers such as melanoma of the skin and prostate cancer. Cancer registries can no longer depend on hospitals alone to achieve complete reporting.

Diabetes program offering training video

The West Virginia Diabetes Control Program is supplying all licensed long-term care facilities and personal care homes with a copy of their training videotape *Caring for the Elderly Resident with Diabetes in a Long Term Care Facility.*

The video is designed to orient and upgrade the skills of staff who have daily contact with residents with diabetes. It was filmed at United Transitional Care Center in Clarksburg and was developed by Lisa Hardman, RN, MSN, CDE, ET; Karen Bray, BA, RN, CDE; and Karen Teagarden, RN, C, CDONA/LTC. The video was produced by Richard McMahan at the West Virginia School of Osteopathic Medicine.

The West Virginia Diabetes Control Program conducts a variety of diabetes education programs and will assist facilities, health professionals and students with diabetes education.

Worksite wellness emphasizes self-care

The Bureau for Public Health is working with the Public Employee's Insurance Agency to provide worksite wellness programs for state employees and teachers. Through an initiative called "Pathways to Wellness," individuals insured under PEIA have available to them informational programs relating to exercise, nutrition, smoking cessation, weight loss and wellness.

A new feature of this program is the inclusion of an emphasis on ***self-care***. Through this program participants have the opportunity to learn when they should consult a physician and when illnesses and injuries can be treated effectively at home. The result should be more appropriate use of the medical care system, lower cost to the insurance provider and the insured, and less inconvenience for the individual. Participants in the program each receive a copy of a self-help book published by the American Institute for Preventive Medicine.

As important as it is not to misuse the resources of hospitals, clinics and emergency facilities, it is also important that signs and symptoms of serious illness not be overlooked or minimized and that medical attention is brought to bear as quickly as possible. For this reason, the self-care materials help the participant in the program to realize when they should consult a doctor.

Programs like this can help to increase a patient's understanding of his/her condition and thus improve communication between physician and patient.

Office Managers Association

Annual Fall Conference

October 22-24, 1998

Flatwoods, WV

Seminar Program

Thursday, Oct. 22, 1998

- Y2K - SQUASHING THE MILLENNIUM BUG - Valuable information about preparing your practice for the year 2000. If your office is not prepared, your business could be in serious jeopardy. Presenter - Steve Carter.
- HARVESTING YOUR KNOWLEDGE - Participants are encouraged to bring troublesome and/or challenging management issues to this forum for discussion with peers.
- CONFERENCE DINNER MEETING - Governor Cecil H. Underwood has been invited to be our guest of honor and keynote speaker. The future of health care and proposed legislation to be addressed.

Friday, Oct. 23, 1998

- HIRING - IS IT ALWAYS A GAMBLE - What to look for when reviewing a resume and how to use the information to conduct an effective job interview. Presenter - Wendy Enelow
- HOW TO AVOID USING A COLLECTION AGENCY - Tips on Accounts Reviewable Management. Presenter - Todd Rulio
- OIG HEALTHCARE FRAUD & ABUSE - Compliance Strategies & Survival Tactics. Presenter - Susie Smith
- INSURANCE PAYORS WORKSHOP - Several principal payors will participate and provide updated material. Presenter - Dr. Steven Powell

Saturday, Oct. 24, 1998

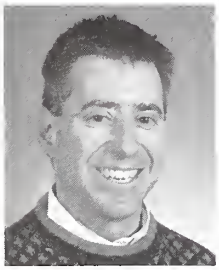
- FREE TO ACHIEVE - This unique program focuses on achievement through personal and professional development. Presenter - Corathers' Health Consulting.

Conference Fee: *Member - $150* *Non-Member - $175* *Lodging $59 single $64 double*

To request conference registration brochure or for further information, please contact: Julia Loeffler, (304) 598-1146 or Donna Lee, (304) 325-3666.

Robert C. Byrd Health Sciences Center of West Virginia University News

Psychiatry professor named distinguished teacher in medicine



Fidler

Dr. Donald C. Fidler, professor of psychiatry, is the winner of the 1998 Distinguished Teacher Award in the WVU School of Medicine.

Dr. Fidler, a faculty member since 1987, teaches an introductory course in psychiatry and supervises the outpatient psychiatry clinic.

"He is recognized as a teaching treasure by peers and students nationally," says Dr. Mary Ann Antonelli, chair of the distinguished teacher committee.

Dr. Fidler has been a visiting professor at St. George's University School of Medicine in the Caribbean, and at the Kodiak Area Native Association in Alaska. He is nationally recognized as an educational video actor-producer-director, and his videos are used in medical schools, psychiatry residency programs and CME sessions.

Combined MD/MPH degree being offered

Medical students at West Virginia University are being offered the opportunity to earn a master's degree in public health, by taking a one-year break from their medical studies.

The combined MD/MPH program takes five years to complete. The MPH part of the program emphasizes preventive medicine and community health.

Students presented international travel awards

The International Health Program has presented International Travel Awards to four students in the Class of 1999. Dr. Robert D'Alessandri (*left*), vice president of health services and dean of the WVU School of Medicine, and Dr. Wesley Farr (*right*) of the International Health Program are pictured with recipients Philip Yin, Chris Simon, Mithu Molla and Amy Lipscomb.

Dr. Williams to lead Center for Rural Emergency Medicine

Williams

Dr. Janet Williams, an associate professor of emergency medicine, is the new director of WVU's Center for Rural Emergency Medicine.

Dr. Williams, formerly assistant director and director for research, replaces Dr. John Prescott, the founding director of the Center. Dr. Prescott will continue as chair of emergency medicine at WVU, and serve as the Center's associate director.

Dr. Williams joined the WVU faculty in 1992 and is board certified in emergency medicine.

Dr. Ducatman honored

Dr. Alan Ducatman, chair of the WVU Department of Community Medicine, is the recipient of the Robert A. Kehoe Award of Merit from the American College of Occupational and Environmental Medicine.

Dr. Ducatman has authored almost 100 publications on the subject of occupational health.

Douglas E. McKinney, M.D.

"A proven leader and physician advocate"

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- Board Certified Urologist
- Third-term WESPAC Chairman
- Medical Assurance of WV Advisory Council
- Past Chairman, WV Medicare Advisory Council
- Five-term President of the WV Urological Society
- Clinical Associate Professor of Urology, WVU School of Medicine
- Past President, Harrison Co. and Boyd Co. (KY) Medical Societies
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Marshall University School of Medicine News

MU second in nation in primary care grads

Marshall's School of Medicine has the second-highest percentage of graduates in the nation entering primary care specialties, according to the Association of American Medical Colleges.

For the three-year period studied, 45.96 percent of MU's grads entered careers in family practice, general internal medicine and pediatrics. Mercer University led with 51.78 percent, and the University of South Alabama and Wright State University closely trailed MU with 45.83 and 45.8 percent, respectively.

MU's graduates enter primary care specialties at a rate more than 50 percent above the national average of 30 percent. This is the second time the school has held the No. 2 slot.

"We are extraordinarily pleased, but not surprised," said Dr. Charles H. McKown Jr., dean of the School of Medicine. "We pride ourselves on the cost-effective production of fine primary care physicians, and this tells us we're getting the job done."

Other schools rated in the top 10 are Michigan State University, the University of South Dakota, the University of Washington, East Tennessee State University, the University of Minnesota and the University of North Dakota. AAMC rankings also showed MU above the national average in the percentage of 1997 grads planning to practice in state: 68 percent of MU grads with stated plans said they planned to remain in state, compared to 60 percent nationally.

This year MU also received a Bronze Award from the American Academy of Family Physicians in recognition of having more than 20 percent of its grads enter residencies in family practice.

Mufson achieves highest ACP rank

Mufson

Dr. Maurice A. Mufson, professor and chairman of medicine, has been elected to the rank of master in the American College of Physicians.

This honor is granted to fewer than one-half of one percent of the association's 100,000-plus members: there are just 351 masters worldwide.

Dr. Mufson becomes the third ACP master in West Virginia. The others are Dr. Warren Point of Charleston, who recommended him for the honor, and Dr. Robert Marshall of Huntington. He was selected for "his contributions to our understanding of infectious disease and his service to organized medicine," according to the printed program for the convocation.

A graduate of the New York University School of Medicine and Bucknell University, Dr. Mufson joined the Marshall faculty in 1976 as founding chair of the Department of Internal Medicine. He is a former president of the Association of Professors of Medicine and has been selected as chair of the Federated Council of Internal Medicine.

Wilderness medicine program offered at MU

New family practice doctors with a thirst for adventure will be right at home at Marshall, which is offering the nation's first wilderness medicine track in a FP residency program.

"This program is an outgrowth of our school's main goal, which is to develop primary care physicians," said Dr. John Walden, director of the new program and associate dean of the School of Medicine.

"Quality medical care is not defined by hospital walls or even by walls at all," Dr. Walden said. "In this state we have world-class expertise in adventure activities such as rock climbing, mountain biking and white water rafting, and here at Marshall we have people with extensive knowledge of jungle trekking, dive medicine and high altitude medicine.

"Combining that expertise through this program will help us draw to West Virginia exactly the kind of new physicians who are likely to appreciate our state's unique qualities and remain here," Dr. Walden added.

Participants in the program will complete a fully accredited residency program in family practice, receive special training in community-oriented family medicine with an emphasis in wilderness medicine, and complete electives in wilderness settings. They will take a land navigation course, get training in the use of Global Positioning System devices, and learn how to apply medical knowledge and techniques to outdoor adventure situations.

The program, which was announced in July at the scientific session of the Wilderness Medical Society, will begin interviewing applicants this fall for up to two positions. It is the third pioneering track developed by Marshall's family practice program, which offered one of the nation's first rural medicine tracks and the nation's first international medicine track for family practice residents.

UNIVERSITY OF KENTUCKY

Neurological Sciences Symposium

- Practical Management of Neuromuscular Disease;
- Medical and Surgical Treatment of Movement Disorders;
- Neurologic Emergencies for the Primary Care Provider

October 23-24, 1998
Holiday Inn North
Lexington, KY

Designed for neurologists, internists, emergency medicine physicians, psychiatrists, and primary care physicians

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1021 National Road, Wheeling, WV

West Virginia School of Osteopathic Medicine News

Governor addresses WVSOM graduates

Governor Cecil Underwood was the keynote speaker for the West Virginia School of Osteopathic Medicine's 21st Annual Commencement ceremony on May 30.

"West Virginia has come a great distance in addressing the need for health care, and this institution has been an important part of that process," Governor Underwood said. "On behalf of all West Virginians, I thank you for your dedication to the people of this state.

"I commend the progress of this institution during its history. By expanding your facilities, you have expanded your service to the people of West Virginia," he added, pointing out the school's latest project - renovation work on a $2 million library facility.

AOA accredits GVMC

Greenbrier Valley Medical Center (GVMC) in Fairlea has received a two-year accreditation from the American Osteopathic Association (AOA) as an accredited osteopathic training facility, according to offficials from GVMC and WVSOM.

"The accreditation shows that the facility's environment is conducive to the philosophy and standards of osteopathic medicine," Kathy Conforti, vice president for quality management at GVMC stated. "The AOA usually awards only a one-year accreditation for a first-time facility. To be awarded a two-year accreditation was delightful and shows that we are a quality health care facility," she added.

WVSOM students visit Lewisburg Elementary

Third-year medical student Abby Wilson of Lewisburg talks with children at Lewisburg Elementary School when she and several other students visited recently as part of an Outreach activity for WVSOM.

Five graduating seniors receive special honors

Several seniors received academic and service awards as a part of Senior Week activities at WVSOM.

Beth Jenkins of Morgantown received the Outstanding Senior Award for best exemplifying the qualities of scholarship, osteopathic professional interest, leadership and citizenship. She was also recognized as an honor graduate and for her membership in the national osteopathic service fraternity, Sigma Sigma Phi.

Charles Leckie of Natchez, Miss., was presented with the Gates Pharmaceutical Award for excelling in family practice.

Connie Anderson and Karen Snider of Lewisburg, and Barbara Williams of Metter, Ga., were awarded the American Medical Women's Association Glasgow Memorial Achievement Citations for being the top female students in their class. All three women were also recognized as honor students and as members of Psi Sigma Alpha, a national osteopathic scholastic honor society. Anderson and Snider were also honored as Sigma Sigma Phi members.

Anderson was also presented with the Society for Academic Emergency Medicine Excellence Award, while both Anderson and Snider were recognized as past Auxiliary to the American Osteopathic Association Scholarship winners.

DeBord honored for distinguished service

Martinsburg area primary care physician Jeffrey B. Debord, D.O., was presented with the WVSOM's Distinguished Service Award during graduation ceremonies on May 30.

This award is presented annually to the individual who has made a significant contribution to WVSOM and medical education in the state.

7th Annual

KEYNOTE Symposium SLEEP Medicine '98

October 2, 1998

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Insomnia
Pediatric sleep
Sleep related breathing disorders & cardiovascular complications
Sleep related breathing disorders & surgical updates
Sleep & erections
Narcolepsy

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Richard Ferber, M.D.
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Together - We have made a difference!

The dog days of summer are here, which means my term as president of the WVSMA Alliance is nearing its end. I am looking forward to the WVSMAA Annual Meeting and the excitement of The Greenbrier, where we will welcome AMA Alliance President-Elect Ann Hansen.

The Summer Board Meeting and the 1998-99 Board Orientation were held at the WVSMA office in Charleston July 28. The meeting was very successful and hopefully will become a regular part of Alliance activities. I would like to thank everyone who was able to attend and take part in the meeting.

Thanks to all of you, Jerry Crites and I were privileged to attend the AMA Alliance Annual Convention in Chicago in June. It was a pleasure to represent you and report on behalf of West Virginia. Also attending the meeting were Jeanny Kalaciouglu, representing Southern Medical, Linda Elliott, AMA Committee member, and Judy Bofill, president of the Philippine Medical Association Auxiliary. I was lucky to be with such a wonderful group of dedicated individuals!

I have enjoyed meeting and working with hundreds of physicians throughout the state and would like to thank them for their unwavering support of the Alliance and its activities. I have had the opportunity to travel a great deal this year and see much of this beautiful state. Thanks to Dr. Chang for his support of the Alliance, as well as his devotion to the WVSMA and the medical profession. It was great working with you! Thanks also to the staff at the WVSMA for all your valuable input and assistance.

Last, but not least, I would like to take this opportunity to thank my fellow Alliance members for your support this past year. It has been a GREAT year! Your warmth, enthusiasm and encouragement has meant so much! I am, like all of you, proud to be a *"physician spouse dedicated to the health of West Virginia"* and I thank you for allowing me to be a part of your remarkable success! The county Alliances and each Alliance member are vital parts of the national federation and I strongly believe that **TOGETHER - WE HAVE MADE A DIFFERENCE!**

Kathy Fortunato
WVSMA Alliance President

Delegation makes impressive showing

It's the time of year when those of us who are new third-year students are glad for the change of scenery as we move into the clinical setting - - when the rising fourth-year students can see the light at the end of the tunnel - - and when the new second-year students are glad not to be first-year medical students anymore.

With these thoughts in mind, I am pleased to report that 10 medical students from around the state attended this year's AMA-MSS Annual Meeting in Chicago, June 11-14, and all of us became inspired to recruite new members and share the important information we learned. Our delegation increased in number this year, a fact which was noticed by sectional and national leadership. The four students from Marshall University who attended, Brenda Van Fossen, Carmella Evans-Molina, Marie DiFilippo and Sarah Rinehart, were all first-time participants. Hopefully, they will continue to be active and aspire to become the next leaders in West Virginia. Two students from the West Virginia School of Osteopathic Medicine, Ken McDowell and Douglas Kascow, were also able to attend. Ken was presented with an award for recruiting the largest percentage of new members for a school of its size. I would like to congratulate Ken and WVSOM for their continued excellence. In addition, I represented the West Virginia University School of Medicine at the meeting with three other students, Brian Grose, Pete Pantilidis and Mark Cassol.

Many issues important in medical education and medicine in general were discussed at the meeting, including test facilities for the computerized USMLE, human cloning, community service and domestic violence. Besides the wealth of knowledge we gained on a variety of topics, we benefitted greatly from the experience of meeting other medical students, comparing our experiences and discussing the future of medicine around the country.

It would be misleading if I implied that the entire time in Chicago was consumed by the conference; at the end of the day we were able to experience the sights, sounds and cuisine of Chicago. The Bulls, steak houses, Harry Carey's and shopping were some of the highlights of our post-conference agenda.

I would like to thank the WVSMA, AMA and the local chapters for their financial support and professional guidance which made it possible for us to attend this valuable meeting.

Stephen Greer, MSIII
President, WVSMA-MSS

New Members

We are pleased to welcome the following new members to the WVSMA:

Physicians

Manuel M. Angco, MD
Williamson, WV

Narpat S. Panwar, MD
Williamson, WV

Catherine E. Hyndman, MD
Lewisburg, WV

Kris G. Murthy, MD
Charleston, WV

William H. Epstein, MD
Princeton, WV

Mark L. Benson, MD
Wheeling, WV

Vijay K. Chowdhary, MD
Romney, WV

John K. Lackey, DO
Summersville, WV

Rowena Gonzales-Chambers, MD
Princeton, WV

Colleen Jones Meriwether, DO
Lewisburg, WV

Bruce W. Cannon, DO
Beckley, WV

Evangeline C. Pizarro, MD
Wheeling, WV

Cesar R. Pizarro, MD
Wheeling, WV

Juanito Aya-Ay, MD
Parkersburg, WV

Patrick J. Bacaj, MD
Morgantown, WV

Charles A. Lattanzi, MD
Fairmont, WV

Sitaram P. Nayak, MD
Ranson, WV

Geeta D. Jayaram, MD
Charleston, WV

Ralph E. Wood, DO
Moundsville, WV

Surinder S. Kohal, MD
Fairmont, WV

Praphul Misra, MD
Fairmont, WV

Agnes M. Franz, MD
Fairmont, WV

Diego A. Gomez, MD
Ronceverte, WV

William S. Dukart, MD
Ronceverte, WV

Zainab Shamma-Othman, MD
Ronceverte, WV

Ronald S. Jones, MD
Charleston, WV

Rabie H. Zalzal, MD
Keyser, WV

Bernice Schwarzenberg, MD
Kingwood, WV

Michael R. Schwarzenberg, MD
Kingwood, WV

Gregory D. Clarke, MD
Charleston, WV

James M. Holehouse, MD
Morgantown, WV

J. Michael Rollins, MD
Morgantown, WV

Joseph M. Folio, DO
Bridgeport, WV

Terrence J. Reidy, MD
Martinsburg, WV

Dionosio E. Policarpio, MD
Charleston, WV

J. Patrick Galey, MD
Bridgeport, WV

Keith M. Zora, MD
Weirton, WV

In Y. Park, MD
Bluefield, WV

Sok Yi, MD
Ranson, WV

Residents

Ali Salim, MD
Charleston, WV

Maurice W. Baker, MD
Morgantown, WV

Medical Students

Shannon Geer
Lewisburg, WV

Michael A. Albert
Morgantown, WV

Michael E. Gates
Morgantown, WV

Amy A. Jarvis
Morgantown, WV

Sarat Raman
Huntington, WV

Carter A. Kenamond
Morgantown, WV

Timothy H. Knierim
Morgantown, WV

Kraiyuth Vongxiburana
Charleston, WV

WESPAC News

We would like to thank the following physicians and alliance members for their contributions to WESPAC: *(This list includes all contributions made from 3/20/98 to 7/10/98.)*

Physicians

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Phillip R. Stevens, MD
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Michael A. Stewart, MD

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Constantino Y. Amores, MD
Michael O. Fidler, MD
W. C. Morgan Jr., MD

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Obituaries

Henry R. Glass Jr., M.D.

Dr. Henry R. Glass, 73, of Charleston, died July 14 in Myrtle Beach, S.C.

Dr. Glass was a graduate of Mercersburg (Pa.) Academy, West Virginia University and the University of Louisville School of Medicine. He practiced at Charleston Area Medical Center and its predecessors since 1958, where he was a former chief of surgery. He was an emeritus clinical professor of surgery for the West Virginia University School of Medicine, and a staff member at St. Francis Hospital in Charleston.

In addition to being a member of the WVSMA, Dr. Glass was a fellow of the American College of Surgeons, a member of the American Society of Abdominal Surgeons, the Kanawha Medical Society, the AMA, the American College of Sports Medicine and the American College of Emergency Physicians. He was team physician for the Charleston Rockets, a member of Masonic Lodge 20, Scottish Rite Bodies, Beni Keden Shrine, Bream Memorial Presbyterian Church and the Charleston Jazz Series.

Dr. Glass was a veteran of World War II.

Surviving: wife, Shelley Lowman Glass; sons, Henry R. "Hank" Glass III and John H. Glass, both of Charleston; stepdaughter, Sarah A. Lowman of New Orleans; sister, Marian Wright of Westfield, N.J.; and two grandchildren.

Seigle Wilson Parks, M.D.

Dr. Seigle Wilson Parks, 85, of Charleston died at the home of his son, Charles Langfitt Parks in Raleigh, N.C.

Dr. Parks received his bachelor and master's degrees from West Virginia University and his M.D. from the University of Maryland. During World War II, he served as an Army Medical Corps major.

A retired medical director for Chesapeake and Potomac Telephone, Dr. Parks took up painting then sculpture, transforming his Myrtle Road home into a gallery of sorts. Neighbors and visitors would stop to gawk at his 8-foot grizzly bear carved from an elm tree stump, his "Venerable Old Man" bust and an abstract sculpture of a horse in a spring house.

From his basement workshop, Dr. Parks produced swans, Canada geese, eagles, otters, snakes and other wildlife. He became known for his annual "Art Under Arbor" backyard sale of his paintings, drawings and portable sculpture.

Charleston artist and city beautification director Cubert Smith remembers when Dr. Parks enrolled in his sculpture class at West Virginia State College after he had retired as a physician. He earned an associate degree in art.

"He had this loving desire to do sculpture," Smith said, noting that Dr. Parks exhibited a love of life and a kind of youth. Parks helped Smith sculpt the 12-ton "Visit a Vision" located on campus, a tribute to 30 years of integration.

Dr. Parks served as a president of Allied Artists, and Mary Black, former art curator at Sunrise Museum and a member of Allied Artists, remembered Dr. Parks by saying, "He was a person concerned about people. He wanted to bring a lot of happiness to others."

Dr. Parks' art fit well with his approach to life," Smith added.

"We have to have something outside ourselves," Dr. Parks said in 1986. "Something to challenge the mind and the spirit. It has to be meaningful and add greater boundaries to living."

A past president of the WVSMA, Dr. Parks was a member of the American Academy of General Practice, the American Physicians Art Association and Christ United Methodist Church.

In addition to his son, Dr. Parks is also survived by daughters, Eleanor Gaunder of Florence, Ala.; Margaret Parks of Pittsburgh; sister, Margaret Ewing; and five grandchildren.

The family suggests memorial contributions to Hospice, 4513 Creedmoor Road, Raleigh, NC 27612, or the West Virginia University Medical School Scholarship Fund.

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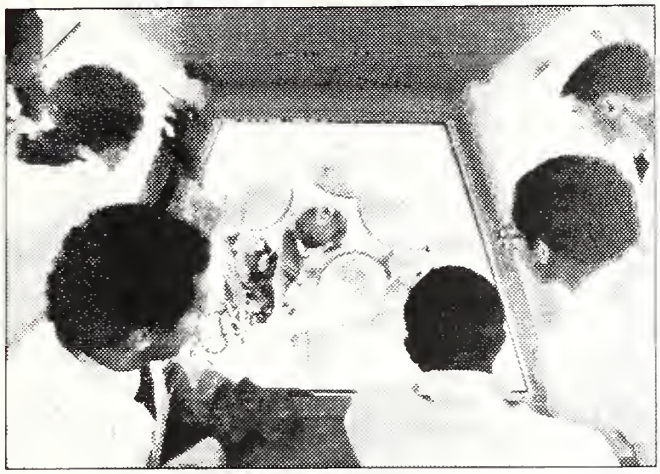

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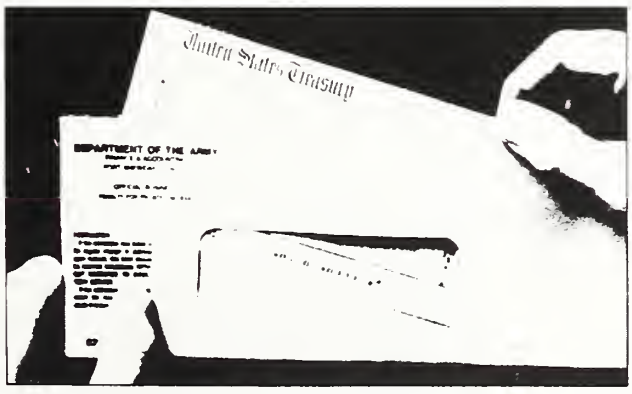

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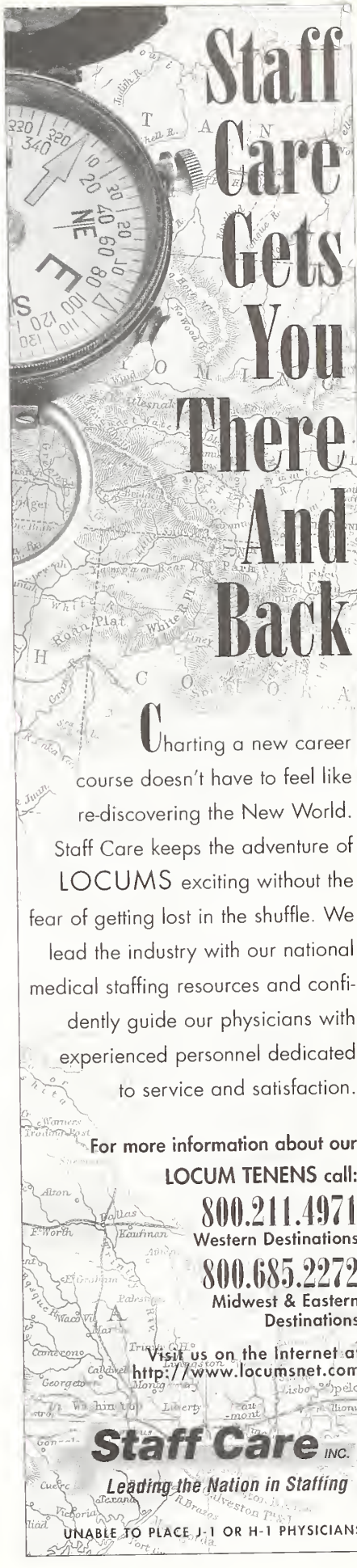

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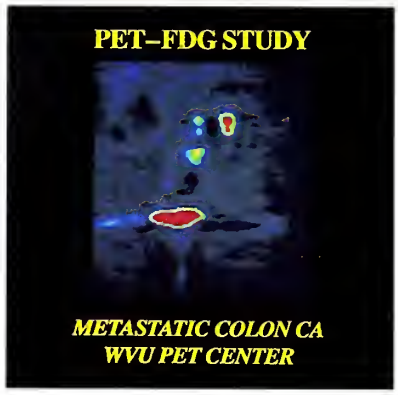

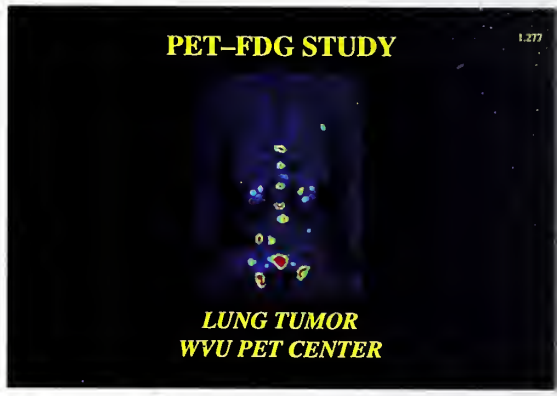

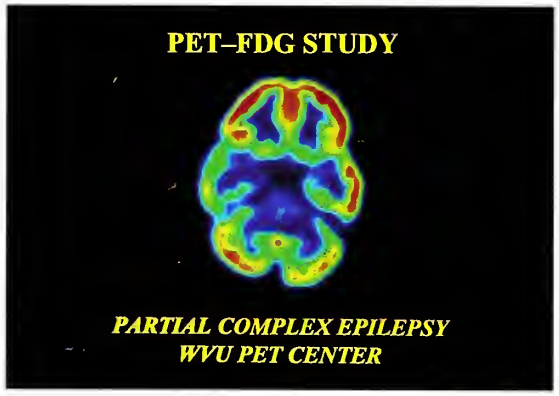

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FDG-PET imaging is very accurate in differentiating benign from malignant pulmonary lesion and in the staging of lung cancer. Because PET has been shown to be cost effective in these indications, Medicare and other third party payers have policies for paying for PET scans performed to evaluate pulmonary lesions and to stage lung cancer. Other indications are being considered for reimbursement by HCFA.

For CME credit on PET, watch for the upcoming PET seminar on Nov. 6-7, 1998.

West Virginia Medical
JOURNAL

Volume 94 No. 5 | West Virginia State Medical Association | September/October 1998

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Seminars:

Issues in Medical Ethics
(four two-hour sessions)
Sept. 22, 1998
Oct. 6 and 27, 1998
Nov. 3, 1998
5 – 7 p.m.
Camcare Health Education and
Research Institute, Charleston, WV

Second Annual Pediatric Critical Care Conference
Oct. 8, 1998, 8 a.m. – 3 p.m.
Robert C. Byrd Health Sciences
Center of West Virginia University
Charleston Division, Charleston, WV

Pharmacology and Women's Health Issues: Outpatient Antibiotics/Pain Control/Weight Loss
Oct. 14, 1998
Robert C. Byrd Health Sciences
Center of West Virginia University
Charleston Division, Charleston, WV

Fifth National Nursing Research Conference: Outcomes of Care in a Changing Health Environment
Oct. 15 - 17, 1998
The Embassy Suites, Charleston, WV

Eighth Annual Vascular Surgery Seminar
Oct. 17, 1998
Robert C. Byrd Health Sciences
Center of West Virginia University
Charleston Division, Charleston, WV

Fifth Annual Childbirth Educator's Day
Oct. 27 – 28, 1998
Coonskin Park Clubhouse,
Charleston, WV

Research Day
Nov. 11, 1998, 5 p.m. – 9 p.m.
Robert C. Byrd Health Sciences
Center of West Virginia University
Charleston Division, Charleston, WV

Clinical Trials Management: The Typical and the Unusual Strategies for Success for the PI and Research Coordinator
Nov. 18, 1998, 9 a.m. – 4:30 p.m.
Robert C. Byrd Health Sciences
Center of West Virginia University
Charleston Division, Charleston, WV

Cardiology Conference at Snowshoe
(with the American College
of Cardiology)
Feb. 2-4, 1999
Mountain Lodge Conference Center
Snowshoe, WV

On-Site Continuing Education Outreach Programs:

Overview of West Virginia Poison Control Center
Oct. 7, 1998, 6:30 p.m.
Fayette County Medical Society
Montgomery General Hospital
Montgomery, WV
Elizabeth Scharman, PharmD

Local Oncology Update
Oct. 13, 1998, 6 p.m.
Plateau Medical Center, Oak Hill, WV
James Frame, MD

Food Borne Diseases
Oct.14, 1998, 5:45 p.m.
Twin Falls Resort State Park
Mullens, WV
Donald Rosenburg, MD

Current Concepts in the Treatment of Otitis Media and Prevention Through Immunization
Oct. 20, 1998, 5:45 p.m.
Days Inn Conference Center
Flatwoods, WV
Austin Wallace, MD
Raheel Khan, MD

Follow-Up Treatment of Common Cancers
Oct. 26, 1998, 5:45 p.m.
Café Acropolis, Summersville, WV
Steven Jubelirer, MD

Prevention of Medication Errors
Oct. 28, 1998, 5:45 p.m.
Tamarack, Beckley, WV
Jeff Hess, PharmD

Prevention of Medication Errors
Nov. 10, 1998, 5:45 p.m.
Sycamore Country Club, Ripley, WV
Jeff Hess, PharmD

Pediatric Surgical Emergencies
Nov. 10, 1998, 6 p.m.
Plateau Medical Center, Oak Hill, WV
Eduardo Suson, MD

Local Oncology Update
Nov. 1, 1998, 5:45 p.m.
Logan Country Club
Chapmanville, WV
James Frame, MD

Common Presentations of Acute Leukemia
Nov. 17, 1998, 6:30 p.m.
Roane General Hospital, Spencer, WV
Richard Williams, MD

Topics in Anti-Coagulation Therapy
Nov. 17, 1998, 5:30 p.m.
David Anderson, MD
Davis Memorial Hospital, Elkins, WV

Prevention of Medication Errors
Dec. 8, 1998, 6 p.m.
Plateau Medical Center
Oak Hill, WV
Jeff Hess, PharmD

Camcare Health Education and Research Institute

9-98

Office Managers Association

Annual Fall Conference

October 22-24, 1998

Flatwoods, WV

Seminar Program

Thursday, Oct. 22, 1998

- Y2K - SQUASHING THE MILLENNIUM BUG - Valuable information about preparing your practice for the year 2000. If your office is not prepared, your business could be in serious jeopardy. Presenter - Steve Carter.
- HARVESTING YOUR KNOWLEDGE - Participants are encouraged to bring troublesome and/or challenging management issues to this forum for discussion with peers.
- CONFERENCE DINNER MEETING - Governor Cecil H. Underwood has been invited to be our guest of honor and keynote speaker. The future of health care and proposed legislation to be addressed.

Friday, Oct. 23, 1998

- HIRING - IS IT ALWAYS A GAMBLE - What to look for when reviewing a resume and how to use the information to conduct an effective job interview. Presenter - Wendy Enelow
- HOW TO AVOID USING A COLLECTION AGENCY - Tips on Accounts Receivable Management. Presenter - Todd Rulio
- OIG HEALTHCARE FRAUD & ABUSE - Compliance Strategies & Survival Tactics. Presenter - Susie Smith
- INSURANCE PAYORS WORKSHOP - Several principal payors will participate and provide updated material. Presenter - Dr. Steven Powell

Saturday, Oct. 24, 1998

- FREE TO ACHIEVE - This unique program focuses on achievement through personal and professional development. Presenter - Corathers' Health Consulting.

Conference Fee: *Member - $150* *Non-Member - $175* *Lodging $59 single*
$64 double

To request conference registration brochure or for further information, please contact: Julia Loeffler, (304) 598-1146 or Donna Lee, (304) 325-3666.

West Virginia Medical JOURNAL

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Managing Editor
Nancy L. Hill, Charleston

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The view from the overlook at Hawk's Nest State Park. Photo courtesy of Stephen J. Shaluta Jr., West Virginia Department of Commerce.

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Manuscript Guidelines

All articles for the *West Virginia Medical Journal* must be submitted on an IBM compatible disc. Wordperfect 5x, Wordperfect 6.0/6.1, Microsoft Word for DOS, and other languages are acceptable. If the manuscript contains tables, the main body of the manuscript and references should be saved as one item, i.e., *article*, and then each table should also be saved as a separate item, i.e., *Table 1, Table 2.*

All scientific manuscripts should be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."* Papers will not be considered for publication if they have already been published or are described in a manuscript submitted or accepted for publication elsewhere. All persons designated as authors should have participated enough in the work to take public responsibility for the concept.

Manuscripts should be accompanied by one extra copy, be double-spaced, have each page numbered and should include a title page, an abstract of no more than 150 words, and references numbered consecutively. No more than 10 references will be published and then a statement will appear that the author should be contacted for the other references listed in the manuscript.

Tables, figures and photos should be numbered, and indicated with parentheses whenever they are mentioned in the text, i.e. (Table 1), (Figure 1). Legends should be included for all figures and photographs.

Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author at a cost of $13 for each photo. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be created in black and white.

All scientific material is reviewed by the editor and three members of the Publication Committee. Depending on their content, other types of articles are usually only reviewed by the editor and should still be mailed to the same address. All articles should be addressed to: Stephen D. Ward, M.D., Editor, *West Virginia Medical Journal*, Charleston, WV 25364.

If you have questions or need more information, phone Nancy L. Hill, managing editor at (304) 925-0342.

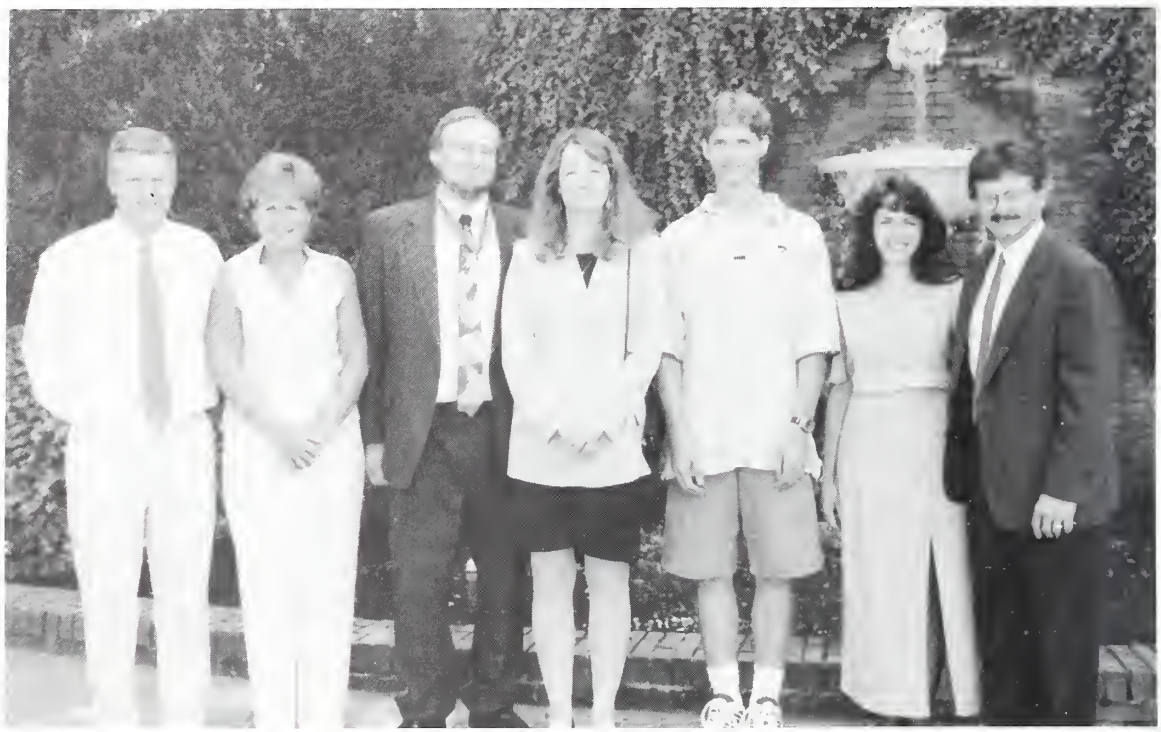
Special Section

Highlights of the WVSMA Annual Meeting

The Greenbrier
August 26-29, 1998

Inaugural Address

A profession, not a job



Following his inaugural address, Dr. Avery enjoyed attending the reception with his wife, Elaine; his son, Seth; and two staff members from his office and their spouses, Laurie Smith, R.N., (*second from left*), and her husband, Ernie; and Pam Hedges, L.P.N., and her husband, Dan.

Honored guests, fellow members of the West Virginia State Medical Association, friends...

Since going into medicine several years ago, I have been asked countless times if my wife and I would encourage our son to pursue a career in medicine. Without fail, this question is always asked on a busy, hectic day and my immediate response is "no."

But is this really true? We all know our profession is painstakingly stressful, dreadfully exhausting and emotionally draining, but in what other profession can you get the ultimate satisfaction of *really* helping someone? We have the ability to help a child through an asthma attack, or an adult with a heart attack, or a gallbladder attack. Conversely, what other profession can make you so unhappy? We have all experienced firsthand the loss of a cherished friend and patient who dies for no good reason, or a child who develops some unknown liver problem and dies within a few weeks.

As if that is not enough, you have your own pain to deal with along with that of the family facing the loss of a loved one. The daily rat race of paperwork, hearings, lawsuits, and the sheer volume of patients all make the medical profession a very intense and difficult way to earn a living. It is at times like these when we ask a lot of questions, but we don't necessarily get a lot of answers. Maybe there are none, but it is more likely we are just asking the wrong questions like the "unanswered prayers" of the famous artist.

Increasingly, companies that have a stake in medicine and its practices, including insurance companies, urgent care centers, and state and federal organizatios, are being managed by people who consider their work to be a job, rather than a profession.

We all know people and companies that work from 9 to 5, not a minute more, not a minute less. Business is expected to fit into a specific time frame in order to be taken care of.

It is organizations with this attitude that are destroying medicine. Most of you are aware of this, and like myself, you are getting increasingly frustrated trying to change it.

The professionals, people with a drive to change things and those who make their vocations a life duty, an endeavor, a full-time lifestyle, need to take charge. Some of the best "professionals" I know are people who work from 9 to 5, but their true profession is not related to their job at all. Whether they be physicians, Little League coaches, foster parents, or scoutmasters, professionals are able to take charge of things and make people's lives better.

It is amazing to me the number of state legislators, officials, administrators who have jobs. They cannot possibly understand the important aspects of pressing issues facing West Virginia if they haven't been absorbed in them. The *"professionals"* really stand out.

In our medical societies, we see the constant pressure to become members, to belong, to get the numbers up. I, personally, would rather see fewer numbers and more professionals — activists with a strong desire to improve things, to take an active role and not just belong.

This year, we will again face the challenge of those with jobs who want to restrict what we do. We cannot let this happen. The hardworking professionals in all fields must work together to take charge of medicine again. We need professionals to serve on boards, on committees, and in organizations. We need to take advantage of this kind of opportunity to offer positive input in order to initiate change.

My role, as your President, is to see that physicians are serving in this capacity and we are doing the best we can to change the direction of where medicine is going.

We all know that the best leaders surround themselves with people who know what is going on. My challenge to all of you is to recruit new professionals, people you believe will lead, rather than settle for the status quo. If each of us could find one other person who will take charge, work hard, and become a professional, a new disciple for medicine, we will see change. *We can make it happen.*

During the year, I want you to know that the West Virginia State Medical Association's officers and staff are here to work with you. We will inform other state health organizations, hospitals, nurses, medical students, whoever is out there, that it is imperative we work together.

Last year, I discovered that West Virginia is the only state in the Southeast Region without a committee composed of health-related organizations that reviews the legislative issues before the opening of the legislative session. We will work to change this.

This could be an excellent opportunity for the West Virginia State Medical Association to increase its awareness about the different issues affecting other organizations in our state. And, while we may not agree on all the issues, we will most likely be united on most of them.

It is truly an honor to have been selected to serve as your President during this year and I hope we can help guide everyone through it. These are very exciting and scary times for physicians. The medical arena is changing more rapidly than we understand. Help us have a successful year. Become involved and encourage others to get involved.

Finally, a word to my son, Seth. When it comes your time comes to choose your life's work, be it an artist, engineer, physician, or even a lawyer, all we ask is that you choose a profession, something that is not only rewarding, but enjoyable and fulfilling as well, and not simply just a job.

Thank you.

David W. Avery, M.D.
WVSMA President 1998-1999

Turning lemons into lemonade

After delivering his Presidential Address, Dr. Chang is congratulated by AMA President Dr. Nancy Dickey, and Dr. Constantino Amores, chairman of the WVSMA's delegation to the AMA.

Thank you. Thank you for what has been such a rewarding year, serving the physicians and patients of my beloved West Virginia. As your outgoing president, I want to express my gratitude to you, for welcoming me to your homes as I traveled throughout the Mountain State this year.

When I began my term as your president, so many of our physicians and patients saw obstacles. Obstacles in their health care system. Obstacles in the giving and the getting of medical care, not only in West Virginia, but throughout the nation.

Now, I am an admirer of the late Norman Vincent Peale and his power of positive thinking. His philosophy is to focus NOT on the obstacle, but on the opportunity it represents. As he might put it, take sour lemons, and turn them into lemonade.

A year ago at this meeting, we were staring at what seemed like a mountain of lemons. And, I am so proud, as your president, that you chose to help me see them not as insurmountable obstacles, but as countless opportunities.

The first group of opportunities we faced was our membership expansion project. I am very happy to report that we have received 155 new physician members, 103 new resident members and 200 new medical student members. This makes a total of 495 medical student members who are the future of our medical association.

Another opportunity was restoring the balance of power of medicine. Or as one of the AMA's past presidents Stormy Johnson said, "Putting the patient back in the driver's seat, with the physician riding shotgun."

We did it with Senate Bill 361, creating a state Patient's Bill of Rights. Rights of people to use the emergency room when they think — in their prudent lay judgment — that they have an emergency. Rights of mothers and newborns to stay in the hospital until their doctors — NOT their insurance plans — say they can go home, or the right of West Virginians to have candid health care discussions with physicians without restriction from their health plans; the right to know about their physicians, hospitals and health plans. Not just what their health plan covers, but more important, what it does NOT cover. NOT when they need to use their plan, but when they first sign up for that plan.

And, passage of the Child Health Insurance Bill, which guarantees West Virginia's poor the access their children deserve to critical health services. Some 39,000 children can now get the shots, the surgery, the basic medical services so necessary to a healthy future — OUR future.

And speaking of our children, don't forget passage of Senate Bill 744, the protection of physician volunteers at sporting events. A law based on common sense.

Just like the common sense used to allow women direct access to OB-GYN services, to post-mastectomy breast reconstruction, and to cosmetic surgery for domestic violence.

And don't forget the progress we made in relieving intractable pain in the terminally ill. Now physicians are able to prescribe the narcotics our patients need, in the amounts they need, without fear of Board of Medicine retribution.

But you know that there is one area where we haven't yet been able to make progress. West Virginia has the highest rate of infant mortality

in the nation. We hope to change that this year as the Birth Score Bill takes effect.

Now newborns delivered at home or in non-licensed facilities must get the birth defect testing they need within 10 days of delivery. I consider that a tall pitcher of lemonade we squeezed out of Charleston this year.

I am proud of all our work on behalf of the citizens of West Virginia. I am also proud of some of the legislation we won that benefits both patients and physicians.

Like our efforts to reshape the Optometry Bill, restricting the prescriptive authority of non-physicians. And our efforts to broaden the powers of physicians to test the HIV status of patients in situations where health care workers are at high risk for exposure.

And then there is our success at keeping advance nurse practitioners from replacing primary care physicians as medical decision makers in HMOs.

Now I would be less than candid if I didn't admit that there are still plenty of lemons rolling around for Dr. David Avery and his presidential year. Just like the Mountaineers, we didn't win them all. We squeezed the lemon almost hard enough to get the provider tax repealed. But, the state's tobacco lobby didn't agree. They won; we lost.

However, the Governor and his Tax Fairness Commission agreed with WVSMA that it should be replaced with a general excise tax. Like General MacArthur, "we shall return."

We'll also return for tort reform. It's the hardest lemon we've ever tried to squeeze. We've been trying since 1986.

Again, Governor Underwood agree with us when he said that West Virginia is one of very few states that has not attempted to deal with the abuse of the court system. And, we were so excited when he introduced a bill to right that wrong. But, with no follow-through, tort reform fell through.

Again, we shall return.

We'll return with new strategies and better communications tools, such as our newest publication, *"House Calls."* It's a quarterly newsletter targeting legislators and government officials, trying to help them better understand the issues we face in West Virginia medicine.

Communication is important. Be it with legislators, patients or the pubic. I know because I've seen it firsthand in my work with Kathy Fortunato, president of our Alliance this year. What change, what progress communication can bring.

Our spouses' organization has looked the ugly realities of domestic violence and teen smoking squarely in the eye and taken them on. I so admire their educational programs in our schools and in our communities. I know I speak for all West Virginia physicians when I thank you, Kathy and your Alliance members, for your support. For choosing to be partners in our homes, in our offices, in our communities.

The partner in my life for the past 34 wonderful years has been my wife, Wha Ja. I had the pleasure of visiting so many of your medical societies during my presidential year, with Wha Ja by my side. She gave me the support and companionship so essential on those long stretches of highway. Thank you, Wha Ja. Please stand.

And would all the WVSMA spouses please stand. All spouses should be recognized.

And I'd like for the WVSMA staff to please stand as well. Led by George Rider — Nancie Albright, Tim Allman, Nidia Henderson, Misty Ramsey, Nancy Hill, Christina Dixon, Shirleen Lipscomb, Sue Shanklin and Donna Webb, and last but not least our Counsel Michele Grinberg. Thank you for your tremendous help and support.

To President-Elect Dr. David Avery, the Executive Committee and Council members, the speakers, members of the House of Delegates and alternates, my gratitude.

To all of you who have helped make my presidential year a fruitful, enriching one.

Together, we turned lemons into lemonade.

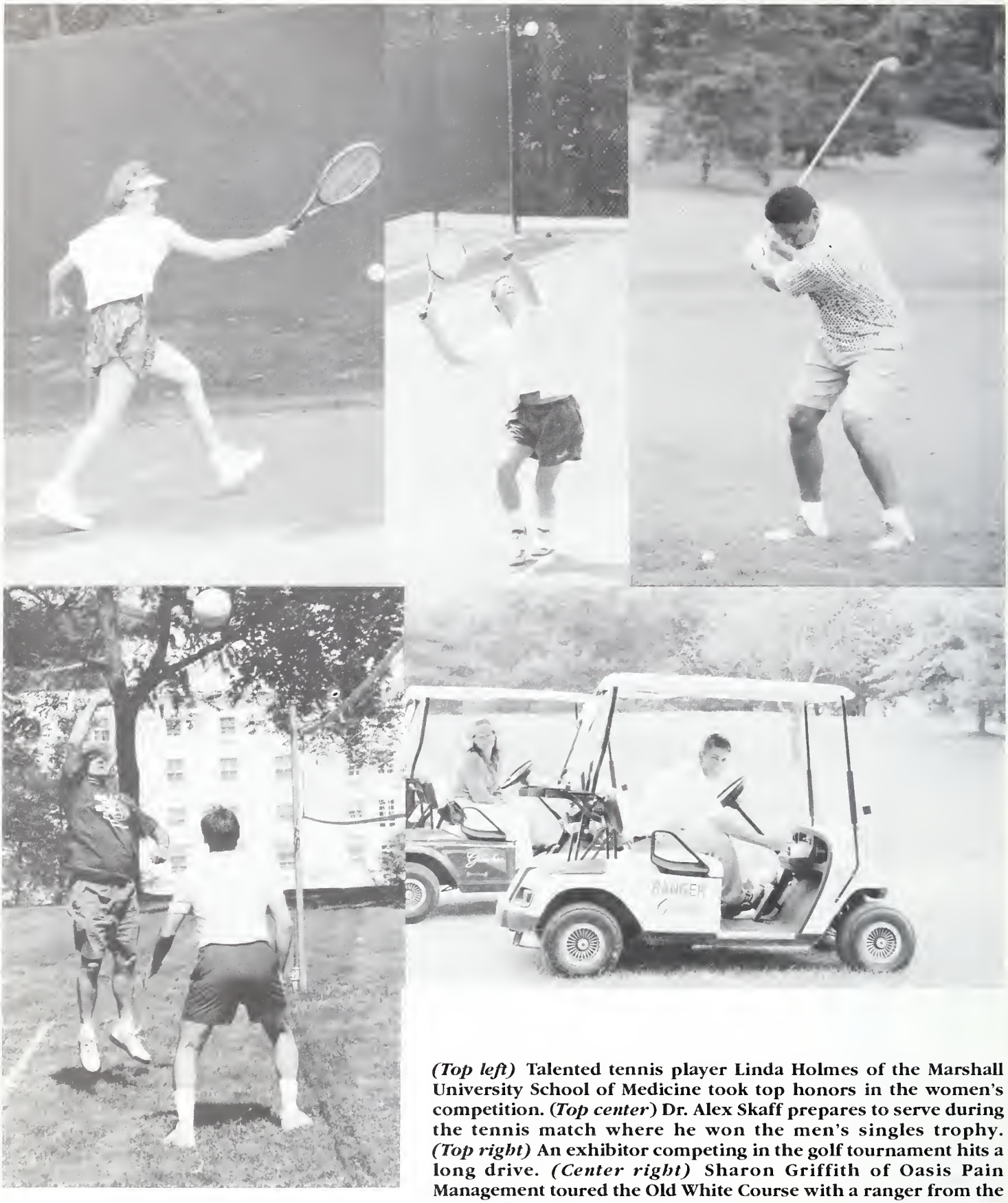
And for that, I thank you.

Thomas H. Chang, M.D.
WVSMA President 1997-98

At the Presidential Reception, Dr. Chang happily poses for pictures with Kathy Fortunato, who served as president of the WVSMA Alliance for the past year, and Dr. Lance Talmage, president of the Ohio State Medical Association. The WVSMA and the Ohio State Medical Association will be holding a joint CME event during the WVSMA's Annual Meeting in the year 2000.

(Top left) **Dr. Alden Harken gestures as he presents his lecture *"Genes Don't Count"* for the First General Session.** *(Top right)* **During his farewell address as WVSMA president, Dr. Thomas Chang shares some humorous insights.** *(Center right)* **Dr. Frank Schwartz addresses a question from the audience during the panel discussion for the First General Session. Other speakers included Dr. Alden Harken (left), Dr. Robert Keenan and Dr. David Pearle.** *(Bottom)* **Drs. Joseph Selby (*front*), Kenneth Allen (*center*), and Generoso Duremdes (*left*) laugh at the wit of Dr. Alden Harken during his lecture.** *(Center left)* **Dr. Albert May, who is chairman of Ohio State Medical Association's Committee on Accreditation for CME Sponsors and a member of ACME, was one of the featured speakers for the Second General Session.**

(Top left) **Hosts for this year's reception by Medical Assurance of WV and Acordia of WV included Medical Assurance leaders Rob Francis, Chuck Ellzey and Dr. Peter Hendricks and his wife.** *(Top right)* **One of the youngest guests at this year's meeting was Mikayla Marie, daughter of Michele Myers of Medical Assurance.** *(Center right)* **Dr. Clemente Diaz and Dr. Rigoberto Ramirez exchange greetings in the Exhibit Hall.** *(Bottom)* **Dr. James Thomas of Greensburg, Pa., was pleased to receive his trophy from Dr. William Scaring, chairman of the tennis tournament.** *(Center)* **Drs. James Helsley and Kenneth Allen won tickets to the WVU/Ohio State football game from the Robert C. Byrd HSC of WVU.**



(Top left) **Talented tennis player Linda Holmes of the Marshall University School of Medicine took top honors in the women's competition. (*Top center*) Dr. Alex Skaff prepares to serve during the tennis match where he won the men's singles trophy. *(Top right)* An exhibitor competing in the golf tournament hits a long drive. *(Center right)* Sharon Griffith of Oasis Pain Management toured the Old White Course with a ranger from the Golf Club to deliver golf tees and towels to the participants. Oasis Pain Management was the sponsor of this year's golf tournament. *(Center left)* Dr. Stephen Sebert spikes the volleyball and Dr. Ron Stollings prepares for the assist during one of the games in the volleyball tournament.**

(Top left) Linda Elliott of the WVSMA Alliance models a coat during the fashion show to raise funds for the AMA Foundation. *(Top right)* Guests at the Alliance fashion show included: *(Front row)* Judy Bofill; Jerry Crites, the new president of the WVSMA Alliance, and his wife, Danine; and Kathy Fortunato, who served as president of the WVSMAA during the past year. *(Back row)* Vickie Casibang, president-elect of Maryland's Alliance; Mildred Taylor of AMAA; Pacita Salon; Rose Romero, president-elect of the WVSMAA; Gwen Pappas, president of the Southern Medical Association Alliance; and Jeanny Kalaycioglu who is president-elect of SMAA and a member of the WVSMAA. *(Center)* A display board about Alliance events and special projects draws attention in the Exhibit Hall. *(Bottom)* Dr. Robert D'Alessandri, vice president for health sciences and dean of the West Virginia University School of Medicine, addressed the WVSMA Alliance members on a variety of topics including his concern about alcohol abuse on college campuses.

(Top left) **One of the highlights of Friday evening's entertainment was a cello performance by Wha Ja Chang, the wife of Dr. Thomas Chang, WVSMA's president during the past year. Mrs. Chang was accompanied on piano by Dr. Stephen Carter, who is her husband's associate.** ***(Top right)*** **Flashing the "PEACE" sign, Alliance leader Kathy Fortunato enjoyed attending the dance with her husband, Dr. Michael Fortunato, and their friends Dr. James Comerci and his wife, Lynn. Dr. Comerci was this year's recipient of the Wyeth-Ayerst Physician Award for Community Service.** ***(Center)*** **Acordia of West Virginia leaders Rob Vass and Tamara Lively (*right*) and Rob's wife Libba were among the guests at the reception hosted by the WVU and Marshall University Schools of Medicine.** ***(Bottom)*** **Couples dance to the music of the band DiSalvo & We Three.**

(Top left) **New WVSMA President Dr. David Avery proudly poses with his son, Seth, and his wife, Elaine, after his inaugural address.*(Top right)* At the reception for the new WVSMA and WVSMAA officers, Jerry Crites, the new president of the WVSMA Alliance, celebrated his installation with his wife, Danine.*(Bottom)* Dr. Michael Fidler of Charleston and his wife, Bonnie, enjoyed hosting two of the visiting state presidents during the meeting - Dr. Richard Geline, president of the Illinois State Medical Society, and his wife, Patricia; and Dr. Allan Jensen, president of the Medical & Chirurgical Faculty of the State of Maryland, and his wife, Claire.**

Resolution 1 *(Sub. Resolution Not Adopted)*

WHEREAS, numerous people from West Virginia State Medical Association have complained about The Greenbrier charges, therefore, be it

RESOLVED, that the WVSMA investigates having the Annual Meeting in different locations.

Resolution 2 *(Adopted)*

WHEREAS, the Medical Student Section of the WVSMA has grown much stronger in interest and numbers, and;

WHEREAS, the costs involved in sending the student delegation to the AMA Meeting are covered by limited grants, and;

WHEREAS, the WVSMA delegation to AMA to show its support of the enthusiasm of our future physicians, therefore be it

RESOLVED, that the West Virginia State Medical Association delegation to the AMA forego the $50/day meal appropriation for each member and use these funds to offer an appreciation dinner for the student section delegates while at the Annual AMA Meeting.

RESOLVED, that the WVSMA express unequivocally its support for the repeal of the 2% physician provider tax.

Resolution 3 *(Sub. Resolution Adopted)*

WHEREAS, vision testing is done only at the initial application for a West Virginia drivers license;

WHEREAS, a person can now legally drive a motor vehicle for 60 years or more without vertification that they can see well enough to steer their automobile safely (3,000-4,000 lbs. of steel) at speeds legally up to 70 miles per hour, therefore be it

RESOLVED, that the West Virginia State Medical Association shall seek the enactment of a law to require persons at the time of their driver's license renewal to be tested for visual acuity in accord with State law governing the issuance of drivers' licesnses.

Resolution 4 *(Sub. Resolution Adopted)*

WHEREAS, the Health Care Financing Administration has issued their Medicare Fraud and Abuse guidelines, and;

WHEREAS, these guidelines place excessive demands on physicians, therefore be it

RESOLVED, that the West Virgnia State Medical Association affirm AMA's policy 9.032 on Health Care Fraud and Abuse:

"1. Physicians must renew their commitment to Section II of the AMA's Principles of Medical Ethics which states that "a physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character, competence, or who engage in fraud or deception."

"2. Physicians should make no intentional misrepresentations to increase the level of payment they receive or to secure non-covered health benefits for their patients."

Resolution 5 *(Adopted)*

WHEREAS, Article VI of the Constitution is amended to elect Councilors from the Medical Association Resident, Medical Association Student and Young Physician's Section, therefore, be it

RESOLVED, the Bylaws, Chapter 7, is amended to add the following language: The Medical Association Resident Section, the Medical Association Medical Student Section and the Medical Association Young Physician's Section shall each have one (1) councilor and one (1) alternate councilor. Each councilor shall be elected at the Annual Meeting of the WVSMA to serve for two (2) years. Each section shall also submit the name of an alternate to act as its representative in the absence of its councilors.

Resolution 6 *(Sub. Resolution Adopted)*

WHEREAS, the Medical Association Resident Section, the Medical Association Medical Student Section and the Medical Association Young Physician's Section now have representation on the Council, therefore be it

RESOLVED, the Bylaws, Chapter VII, Sec. 6, third paragraph, is amended to delete line 28 through 31, beginning with "as being members of the Component Society representative of their mailing address at the time they entered residency training." And amended to insert on line 28 the following: In the Component Society where they declare their residency. And amended to insert the phase in line 27 after the phase "Medical Student Members" and Resident Members.

Resolution 7 *(Adopted)*

WHEREAS, the Speaker of the House acts as parliamentarian for conducting the business of the House of Delegates, therefore be it

RESOLVED, that Chapter 6, Section 1, of the Bylaws be amended to delete the following sentence: The President shall appoint a Parliamentarian to serve during his term of office."

Cancer Committee

The Annual Meeting of the WVSMA's Cancer Committee was called to order by Chairman Catalino B. Mendoza Jr., M.D., at The Greenbrier in White Sulphur Springs on Thursday, August 27, 1998 at noon.

Members in attendance were: Drs. Erlinda De La Pena, Graciano E. Cendana Jr. and Generoso D. Duremdes.

Guests present were Drs. Cordell De La Pena and Juanito Chua; Leslie Given, state education coordinator for the Mary Babb Randolph Cancer Center, Cancer Education and Information Service; Beverly Keener, director, WV Cancer Registry, and Nancye Bazzle, program director of the Breast and Cervical Cancer Screening Program/Office of Maternal and Child Health (BCCSP/OMCH) for the Bureau of Public Health; and Robin Seabury who is also with the BCCSP/OMCH.

The minutes of the Annual Meeting held on August 22, 1997, were approved as issued.

Ms. Bazzle presented an update on the BCCSP/OMCH diagnostic and treatment funding during the past five years. The program is now able to offer free and low-cost breast exams, mammograms, breast ultrasounds and biopsies, cervical colposcopies and pap tests to women who qualify. This was accomplished through the efforts of the WV Breast and Cervical Cancer Coalition and its partners. Funds were created through Walks for Women, Quilts for Hope, private donations and the West Virginia Legislature appropriation of $250,000.

Ms. Given gave a more detailed report on the fund raising projects of the WV Breast and Cervical Cancer Coalition and its partners. She announced that the first WV Breast Cancer Awareness Day (WVBCAD) was held on October 2, 1995, and that the Fourth Annual WVBCAD is planned for Oct. 2, 1998. Sponsors of this event include:

- West Virginia Breast and Cervical Cancer Screening Program, offered by the WV Department of Health and Human Resources, Bureau for Public Health;
- West Virginia Breast and Cervical Cancer Coalition;
- West Virginia Homemakers;
- General Federation of Women's Clubs, West Virginia;
- American Cancer Society;
- Cancer Information Service;
- American Association of Retired Persons;
- Mary Babb Randolph Cancer Center;
- YWCA EncorePlus; and
- Appalachian Leadership Initiative on Cancer.

Throughout October 1998 the Coalition and its partners are sponsoring 12 regional *"Walks for Women . . . Take a Step Against Cancer"* to raise awareness of the need for breast cancer screening, to honor breast cancer survivors and to remember those who have died from cancer. The Coalition is also working with the state quilt guilds and WV Extension Homemakers to make quilts in honor of breast cancer awareness. They are estimating that 35 quilts will be created for the 1998/1999 project. Last year, this project raised $25,000. For more information, call Leslie at (304) 293-2370.

Leslie announced that a Comprehensive Cancer Prevention and Control State Cancer Plan Summary is under preparation by the WV Breast and Cervical Cancer Coalition. The committee agreed to assist in this endeavor.

Beverly Keener reported that the WV Cancer Registry was preparing data on the surgical treatment of localized breast cancer from 1991-1995 for publication. Also, the WV Cancer Registry has gone through a formal certification process by the North American Association of Central Cancer Registry with a favorable result.

Dr. Mendoza Jr. announced that the *"Fall Cancer Conference: New Strategies in the Management of Lymphomas"* will be held on Oct. 23 at the Robert C. Byrd Health Sciences Center in Morgantown. In addition, a conference on *"Current Trends in PET Imaging"* is scheduled for November 6-7. It was recommended by the Committee that these conference announcements be published in the *WESGRAM*.

Dr. Mendoza Jr. stated that the next annual meeting will be held in August 1999; place, time and date to be confirmed later.

Council Report

August 20, 1997 Meeting

A. Derrill Crow, M.D., gave an update on Medical Assurance of West Virginia stating that he is very pleased with progress made to provide malpractice insurance coverage in West Virginia. He reported that 90 percent of claims tried have been won (20 of 22) and there have been 14 reasonable settlements. He also announced there would not be a rate increase in 1998.

B. Due to complaints of high costs at The Greenbrier, the Executive Committee was directed to pursue other locations. There is no place in WV that can accommodate all of the requirements of our Annual Meeting except The Greenbrier. The Homestead, Hot Springs, Va., could meet our needs and submitted a proposal. The House of Delegates rejected this offer because it was outside of WV.

C. Kathy Fortunato, Alliance President-Elect, acknowledged the assistance provided by the WVSMA staff. She gave an update of the additional $4,000, given to the Alliance by the WVSMA to support their State Alliance Health Projects.

D. Dr. Helsley presented the WVSMA's CME Essentials, Standards and Guidelines and Standards for Commercial Support for review and reapproval. These were approved.

E. It was proposed and approved to replace the Annual Program Committee with a Scientific and Educational Session. If this committee's application for accreditation is approved, it will no longer be necessary to apply for Category I credit through another entity. This committee as an accredited sponsor can designate CME credit. This will also enable us to sponsor one national program per year, our Greenbrier Meeting.

F. Due to our physicians being members of the AMA in large number we were given an additional Delegate and Alternate Delegate in the AMA House of Delegates. We now have four delegates and we will be reviewed in December 1998 for any adjustment to this number.

November Meeting

Due to a lack of a quorum there was no November 1997 Council Meeting.

January 18, 1998 Meeting

A. Dr. Chang discussed legislative issues facing the WVSMA during 1998's legislative session. This included proposed tort reform by the Governor, rule changes allowing optometrists to prescribe medication and do certain surgeries.

B. Dr. Chang reviewed a proposal to have the WVSMA provide management services for the Kanawha County Medical Society. It was approved by Council.

C. It was approved by the Council that the Mid-Winter Meetings for 1999 and 2000 would be held at the Embassy Suites in Charleston.

D. A lengthy discussion was held concerning the financial collapse of P.I.E. Medical Assurance has offered to initially accept former P.I.E. insured without any underwriting so that individual coverage will not be disrupted. These individuals will then be reviewed during 1998 to determine the continuation of their insurability.

May 29, 1998 Meeting

A. It was approved that the format for the 1998 meeting would revert to having the First Session of the House of Delegates on Wednesday and the Second Session of the House of Delegates on Saturday. This is being done to accommodate Dr. Dickey, AMA President, who could not attend other than Wednesday. It will also allow for more CME hours.

B. Dr. Chang gave an overview of the 1998 Legislative Session. Overall, the session was positive for physicians and their patients. A number of onerous bills were defeated and several bills of importance to the medical community were passed. This information has been disseminated to the members through the *Legislative Update* and the *WESGRAM.*

C. A report on the WESPAC endorsements for the Primary Elections was made.

D. Dr. McKinney addressed the Council regarding WESPAC contributions. Unless there is a significant increase in donations, we will have very little monies available for the General Election in November of this year.

Committee on Medical Education

The West Virginia State Medical Association (WVSMA) is recognized by the Accreditation Council for Continuing Medical Education (ACCME) to accredit intrastate providers of Continuing Medical Education. WVSMA has maintained this role since 1972 and to date accredits 25 hospitals and organizations in West Virginia. The program was again re-surveyed in June 1998 and is currently awaiting notification of the results of that survey.

WVSMA is committed to a strong CME program providing physicians with the information needed to deliver quality patient care. We host two major activities each year; the Mid-Winter Clinical Conference and Annual Meeting, as well as other small seminars and biennial workshops for directors and coordinators.

Interest has been expressed in accreditation for sponsorship of CME Programs by the following: Greenbrier Valley Medical Center, Roane General Hospital, Princeton Community Hospital, Barbara Utt, Man Appalachian Regional Hospital. According to procedure, the following material was sent to these organizations and hospitals interested in establishing CME accredited programs:

1. Preliminary Questionnaire
2. Application for Accreditation for CME Program
3. Essentials and Guidelines
4. Standards for Commercial Support of CME
5. Standards for CME of Enduring Materials
6. Physician's Recognition Award Information Booklet

A total of 12 surveys have been conducted since the last Annual Report. Of those, two were initial surveys and 10 were on-site surveys.

Initial applications received and surveyed since the last Annual Report:

Wheeling Area CME
Survey: September 29, 1997
Surveyors: James D. Helsley, M.D., John W. Traubert, M.D., Nancie Albright and Shirleen Lipscomb
Recommended Award: Two-year accreditation

Bluefield Regional Medical Center
Survey: October 20, 1997
Surveyors: Anne D. Hooper, M.D., Shirleen Lipscomb and Tim Allman
Recommended Award: Four-year accreditation

United Hospital Center
Survey: October 27, 1997
Surveyors: James D. Helsley, M.D., Alvin H. Moss, M.D., Tim Allman and Shirleen Lipscomb
Recommended Award: One-year probation with six-month interim report

Mid-Ohio Valley CME
Survey: November 6, 1997
Surveyors: James D. Helsley, M.D., Nancie Albright and Shirleen Lipscomb
Recommended Award: Four-year accreditation with regular annual reports and updates

Columbia St. Lukes Hospital
Survey: December 10, 1997
Surveyors: Lester Labus, M.D., and Shirleen Lipscomb
Recommended Award: One-year provisional with six-month interim report

Monongalia Valley Association of Health Centers (Fairmont Clinic)
Survey: December 16, 1997
Surveyors: John W. Traubert, M.D., Alvin Moss, M.D., and Nancie Albright
Recommended Award: Four-year accreditation with six-month interim report

West Virginia Hospital Association (Healthcare Education Foundation of West Virginia)
Survey: January 6, 1998
Surveyors: Daniel S. Foster, M.D., Nancie Albright and Shirleen Lipscomb
Recommended Award: Four-year accreditation with six-month interim report

Fairmont General Hospital
Survey: March 2, 1998
Surveyors: Nancie Albright and Shirleen Lipscomb
Recommended Award: Two-year accreditation with six-month interim report

Pleasant Valley Hospital
Survey: April 8, 1998
Surveyors: David Bailey, Nancie Albright and Shirleen Lipscomb
Recommended Award: Four-year accreditation

Reynolds Memorial Hospital
Survey: March 3, 1998
Surveyors: Terry Elliott, M.D., Nancie Albright, and Shirleen Lipscomb
Recommended Award: Four-year accreditation

Logan General Hospital
Survey: July 23, 1998
Surveyors: Ron Stollings, M.D., Nancie Albright and Shirleen Lipscomb
Recommended Award: Two-year accreditation with six-month interim report

St. Francis Hospital
Survey: July 24, 1998
Surveyors: Warren Point, M.D., Nancie Albright and Shirleen Lipscomb
Recommended Award: Two-year probation with six-month interim reports

West Virginia Hospital Association Healthcare Education Foundation
Six-month interim report received

United Hospital Center, Inc.
Six-month interim report received

Columbia St. Lukes Hospital
Six-month interim report received

Jackson General Hospital
One-year interim report received

The following 25 institutions/organizations are accredited to offer Category 1 of the Physician's Recognition Award of the AMA by the WVSMA:

Beckley Appalachian Regional Hospital, Beckley, WV

Bluefield Regional Medical Center, Bluefield, WV

Broaddus Hospital/Myers Clinic, Philippi, WV

Charleston Area Medical Center, Charleston, WV

City Hospital, Martinsburg, WV

Columbia St. Lukes Hospital, Bluefield, WV

Davis Memorial Hospital, Elkins, WV

Fairmont General Hospital, Logan, WV

Jackson General Hospital, Ripley, WV

Logan General Hospital, Logan, WV

Mid-Ohio Valley CME, Parkersburg, WV

Monongalia Valley Assoc. of Health Centers (Fairmont Clinic), Fairmont, WV

Pleasant Valley Hospital, Point Pleasant, WV

Raleigh County Medical Society, CME Program, Beckley, WV

Reynolds Memorial Hospital, Glen Dale, WV

St. Francis Hospital, Charleston, WV

St. Mary's Hospital, Huntington, WV

Thomas Memorial Hospital, South Charleston, WV

United Hospital Center, Inc., Clarksburg, WV

VA Medical Center, Martinsburg, WV

Weirton Medical Center, Weirton, WV

WV Academy of Ophthalmology, Charleston, WV

WV Academy of Otolaryngology, Charleston, WV

WV Hospital Association, Charleston, WV

Wheeling Area CME Program, Wheeling, WV

The Committee continues to monitor each organization and its compliance with the Essentials and Guidelines and the Standards for Commercial Support and Enduring Materials set by WVSMA through annual reports and random visits. The revised Essential 7 was implemented June 1, 1998 in West Virginia. WVSMA staff has taken copies of the new essential and the new accreditation statement on each survey completed since June 1. Numerous communications have been sent to all sponsors in the year preceding.

The CME newsletter *"CME Network Connections,"* initiated in the Spring of 1998 is published quarterly at the WVSMA headquarters. The newsletter has been an invaluable tool in our ongoing efforts to maintain better than average communications with our sponsors. In the short time since its inception, we have successfully invited and published articles by National CME professionals as well as articles written by WV sponsors, and we plan to continue to do so. The newsletter is still mailed to CME providers, their directors and coordinators, Medical Education Committee Members, and the Executive Committee.

Nancie Albright attended the 23rd Annual Alliance for CME Annual Conference from January 28-31, 1998, in San Diego, Calif. She participated in a national survey this year serving as Chair for the Texas Department of Health with Henry Tulgan, M.D., on August 4, on behalf of the Accreditation Review Committee of the Accreditation Council for Continuing Medical Education (ACCME). This initial survey took place in Austin, Texas. Nancie also participated in the Oklahoma State Medical Association's resurvey for State Recognition on September 19 in Chicago, with Richard Ashby, M.D. All expenses for these surveys are paid by ACCME.

The 1997 Annual Reports were received and presented to the Medical Education Committee for review and approval.

WVSMA's CME Accreditation Program was resurveyed, reverse-site on June 13, 1998, at the AMA in Chicago by the ACCME. The result of the survey will not be known until the Committee for Review and Recognition (CRR) meets in September in Chicago. The CRR will act upon the surveyor's recommendations at that time, and we should expect to hear shortly after this meeting. Dr. Steven Minnick, director of the Department of Medical Education at St. John Hospital and Medical Center in Detroit, Mich., served as chairman of our survey team, and Dr. Frank White, CME chairman of the Tennessee Medical Association, and Kate Regnier, ACCME staff, were the reverse site-surveyors. The surveyors were highly complimentary of *"CME Connections"* noting that WV is one of the few states to have accomplished such a publication and continues to print and keep it on time.

In addition, Nancie attended the ACCME/State/Territory Medical Society Conference, September 18-19, 1998, in Chicago, and facilitated the Friday morning session on *"System98."* This year's conference focused on two areas of critical importance which will be explored in depth:

1) Implications of the ACCME's new system of accreditation for state/territory medical society accreditors, and;

2) A review of the results of the 1998 State/Territory Medical Society Survey.

Mid-Winter Clinical Conference

WV State Medical Association

Embassy Suites, Charleston, WV

January 21-24, 1999

Registration *Form*

Name _____

Address _____ City/State/Zip _____

County _____ Specialty _____ Phone _____

Payment by: _____Check _____ VISA _____ MasterCard

Card Number _____

Expiration Date _____

Signature _____

• Cancellation Policy: There will be a $50 administrative fee for cancellations after December 15, 1998

If paying by check, please send registration form and check to:
West Virginia State Medical Association
P.O. Box 4106, Charleston, WV 25364
(304) 925-0342 Toll-free: (800) 257-4747
or FAX to: (304) 925-0345

Early Bird Special – Before Jan. 1, 1999

❒ WVSMA Member $115 ❒ Non-Member $165

Registration Fees – After Jan. 1, 1999

❒ WVSMA Member $125 ❒ Non-Member $175

Lunch & Learn – Saturday, Jan. 1999

Subject will be Child Abuse and Neglect. Title to be announced at a later date.

❒ Physicians $50 ❒ All others $35

To receive a special room rate, call the Embassy Suites at (304) 347-8700.

Membership

We know it is like preaching to the saved, but we would like to point out some problems with membership that medical organizations are having throughout the country.

Happily, these problems are not currently very pressing in West Virginia. Our current membership is over 2,700 and has increased each of the last four years. These figures represent increases in each category of membership, active, medical student, resident and retired. Membership has gone through some lean years, but present figures approximate those of the top years during the 1980s.

Many state medical organizations have experienced a reverse trend and have had to cut back services. Nationally, the AMA regards the direction membership has taken as worrisome or even ominous because of its potential for affecting Medicine's lobbying stature.

For generations, AMA has had the distinction and reputation of having the most formidable lobby in Washington. This regard for our effectiveness has been based on something other than the number of our lobbyists whose count is minuscule in relation to those of many other eager and partisan groups. Medicine's lobbying effectiveness is based on the quality and knowledge of our lobbying personnel, the research and preparation capabilities of the AMA Legislative Department and to the importance American voters attach to anything which might threaten the quantity and quality of the medical care they currently enjoy.

Where might American doctors be without such representation? And what is truly frightening, where might American health care be without that same representation? Worldwide, when one thinks of quality medical care one must then think of AMA which has set and enforced education, research, teaching and treatment standards for the United States and thence for the entire world. Medical ethical standards have been set, monitored and enforced by AMA for generations. All these apply not just nationally, but through AMA's influence worldwide.

Many physicians complain AMA and state medical dues "cost too much." They allow you, the paying members, to bear the burden. Their short-sighted miserliness affects and threatens all of us, themselves and their patients included. Joining and participating in AMA activity is not like joining the country club. There is comradeship and cohesiveness here, but the level of pleasure and satisfaction one can expect from membership with us is on a different plane than one experiences in other memberships. Needless to say, membership costs, as a percentage of income, when compared to union dues paid by many of our patients, are not very substantial.

Some maintain that participation in their specialty organization fulfills their oligations to Medicine. None of these organizations, however, carry on the critical representative activities at the state, national and international levels that are characteristic of the AMA alone. Most specialty organizations have their activities confined to the promotion of intellectual, scientific, technical and sometimes legislative matters important to that specialty. Such are worthy enough, but only AMA speaks for all aspects and interests of Medicine.

West Virginia physicians are to be commended for their traditional solid support for organized medicine. Were other states to match West Virginia's record of support, we could all be much more optimistic about the future of Medicine. Our state office, which is responsible for the maintenance of all its services as well as our membership levels, also merits kudos for its performance in accomplishing these and for promoting WESPAC involvement and representing our interests before the Legislature and the various bureaucracies in Charleston.

Stephen D. Ward, M.D.
Editor

Letters To The Editor

Flu vaccination decreases morbidity risk for diabetics

Diabetics are more likely to die from complications of influenza than people without hyperglycemia. From 1985 through 1987, national surveys on the health and mortality of the U.S. civilian population concluded that people with diabetes are about three times more likely than people without diabetes to die from flu and pneumonia-related complications.

Each year, 10,000 to 30,000 people with diabetes are die from complications of the flu and pneumonia. During flu epidemics, people with diabetes are six times more likely than people without diabetes to be hospitalized, and their death rates may increase five to 15 percent. This risk is particularly high when additional risk factors such as cardiovascular disease and kidney disease are present.

It is estimated that immunizations could prevent up to 80 percent of deaths associated with the flu, yet nearly two in three adults with diabetes do not get a simple, safe flu shot. Aggressive efforts need to be taken to increase influenza immunizations levels among people with diabetes in order to decrease flu-related morbidity and the number of preventable deaths.

Typically, physician-regulated diabetes care emphasizes aggressive control of the disease to retard the onset and progression of long-term complications affecting the eyes, kidney, and cardiovascular and nervous systems. Concentration may be only on diabetes itself, and not on the overall health of the patient. As a result, we may overlook general preventive measures, such as flu shots, that we would utilize with our patients without diabetes.

CDC is launching a national awareness campaign this fall to encourage people with diabetes to get a flu shot before flu season, which is generally November through March. We also recommend a pneumococcal vaccine for people with diabetes. Nationally, representative data suggest that less than one in six persons with diabetes are immunized against pneumococcal pneumonia.

You can help by including influenza and pneumonia vaccinations as part of a regular diabetes management program. Please encourage your patients to be vaccinated to protect themselves from these preventable risks and "take control of their diabetes."

Frank Vinicor, M.D., M.P.H.,
Director, Division of Diabetes Translation
Centers for Disease Control and Prevention

Above all do no harm?

Jack Kevorkian used to call what he does "medicide" until it was pointed out that the term literally means "the killing of medicine." Many feared that killing the medical profession was exactly what he would accomplish if he succeeded in turning physicians into agents of death who were authorized to put the sick out of our emotional and financial misery. But it appears to already be too late.

Although partial-birth abortion has been condemned by the medical profession as never justified, the profession has taken no action against its practitioners. Why not? What kind of mind does it take to hold a perfectly formed human child squirming in one's hands and then puncture its skull and suck its brains out? Do such as these really qualify to be called medical doctors? Then why are they still members of the profession in good standing and allowed to continue this horrific practice?

The byword of the medical profession used to be "above all do no harm," and the Hippocratic Oath used to say "I will give no deadly medicine." It also included an explicit prohibition against committing abortion. (Perhaps this has something to do with why it has quietly disappeared from many medical schools.) What has become of the medical profession when it welcomes into its ranks those unethical practitioners who have prostituted their skills to destroy human life, accepts abortion when there is no medical indication, and intrudes itself into families by condoning surgery on minors without parental permission or knowledge? Yet many, duped by the wedge issues of pain and personal autonomy, want to trust this thoroughly corrupted brotherhood with end of life decisions for the weakest and most vulnerable among us.

We are not far from the experience of the Netherlands where euthanasia is legal. The Dutch now fear entering their own hospitals where many lives are involuntarily ended in spite of so-called safeguards.

Alfred Lemmo
Dearborn, Michigan

Special Article

Prescribing medications and malpractice suits: Clear, consistent documentation is the key

KATHI BURTON, M.S., H.R.M., F.A.S.H.R.M.
Regional Manager, Risk Management Services, Medical Assurance of West Virginia, Inc.

When I visit physicians' practices to check for potential risk management problems, I am often shocked to find that many doctors have not implemented adequate procedures to prevent medication-related problems that may harm patients and lead to litigation.

Physicians must have documentation that is clear, consistent, and complete when they prescribe medication. Incomplete, illegible and inconsistent drug documentation can cause not only errors and injury, but if litigation occurs, these deficiencies suggest careless, negligent prescribing practices when none occurred. To avoid weaknesses in charting medications, avoid the following:

(1) Charting prescriptions only in the text of daily progress notes where they may be overlooked especially in voluminous medical records.
(2) An ambiguous note, such as "refill meds," when read as written indicates that all current medications are to be refilled, when refill of only one of several drugs was intended.
(3) Incomplete notes, such as "prednisone for inflammation," with no indication of the amount of frequency, offer the physician little protection if a pharmacy error occurs or the patient claims to have been given improper dosage instructions.
(4) Illegible handwriting and carelessly written decimal points and numbers, and unclear abbreviations which can compromise quality patient care.
(5) Lack of documentation regarding injections because this could jeopardize the defense of a case. Patients should be observed for a specified amount of time after receiving certain medications such as antibiotics, allergy meds, and analgesics. Documentation regarding the administration of all medication injections should include:

- Medication administered
- Dosage
- Injection Site
- Signature/initials of person administering injection
- Side effects and/or complications

A serious misadministration of a drug through improper dosage, incorrect drug, or one which the patient is known to be allergic - is extremely difficult to defend. To prevent dangerous or lethal medication errors, follow these risk management tips:

1. Double check the vial or bottle label prior to drawing up any substance. Never permit the existence of unlabeled vials or bottles in your office.
2. Make sure anyone writing or phoning in prescriptions gives complete dosage instructions to pharmacist and avoid "take as directed." Patients do not remember oral instructions.
3. Prescriptions and other written instructions must be **legible!!**
4. Copies of all prescriptions should be maintained in the medical record including written copies of phone orders.
5. Prior to the administration of any medication by any route, ask the patient if he/she is allergic to the drug or drugs to be administered - even when there is no indication of drug allergy on the chart.
6. All personnel dealing directly with patients should be trained in cardiopulmonary resuscitation and be re-certified. Physicians and staff should know the location and use of oxygen and other resuscitative equipment and drugs.
7. A prescription protocol should be established by the physician(s). Protocols should include:

- Who is authorized to OK refills.
- Dosage instructions or refills should either be to continue with current directions or be spelled out. Never say "take as directed." Do not allow a plaintiff's attorney to hold up a bottle with "take as directed" and interpret what that means to the plaintiff's advantage.
- Never let office personnel guess if they cannot read your instructions. (Do not end up in court because your office staff is afraid to tell you when they are not sure what you mean.)
- When phoning in prescriptions, the caller must identify the prescribing physician; *West Virginia Surgery Center cannot write prescriptions, but John Doe, M.D. can.* It is illegal for pharmacists to fill prescriptions if they cannot identify the prescriber.

8. Controlled substances prescriptions require special attention.

   - Only one prescription on a prescription blank. Federal law prohibits combining prescriptions for control and non-control drugs on the same blank, as well as prescriptions for more than one control substance on a blank.
   - Class II prescriptions must be in writing (does not preclude typing or computer generated prescriptions signed by the physician).
   - There is no law precluding filling of Class II prescriptions after 72 hours. **THIS IS A MYTH!!!**

9. Controlled substances in a medical office must be inventoried, must be maintained double-locked (a locked cabinet in a locked closet or a locked box in a locked cabinet). Records of drug acquisition and disposition must be maintained. A sample Narcotic Inventory Control Record is shown below.

NARCOTIC INVENTORY CONTROL RECORD

Name of Drug _____ **Strength** _____

Date	Amount Added or Returned	Amount Issued	Issued To	Admin. Record Number	Date Admin. Rec. Returned	Issued By	Balance on Hand

Actual Balance on Hand _____ **Balance Carried Forward** _____

10. Sample medications should be maintained in a central location of the medical office, not in patient exam rooms, so some degree of security can be maintained. When sample drugs are distributed to patients, it is recommended the patient be given written instructions regarding the medication. These instructions should include the amount to be taken, how often, the route, the duration and any special precautions or instructions. The distribution of these instructions should be documented in the medical record.

    Sample medications should also be inspected for expiration dates. A Sample Drug Log like the one shown below should be maintained to include the date of the inspection and the person performing the inspection. In the event of a drug recall, a Sample Drug Log will identify the lot number and the patient receiving that lot number.

SAMPLE DRUG LOG

Medication: _____
NDC: _____
Lot #: _____
Exp. Date: _____
Company: _____
Number of Samples: _____
Logged in By: _____

Date	Patient Name	Account #	Amount Given	Amount Remaining	Initial

11. During risk management surveys of medical office practices, it is difficult to determine patients complete medication regimen without reviewing the entire medical record.

    A medication control record should be used by the physician to monitor all current and new medications the patient is taking. The medication control record should be located in the front of the patient's medical record and look like the sample below:

MEDICATION CONTROL RECORD

Patient Name: _____

Allergies: _____

Date	Medication	Dosage	#	Refill	Reaction

Drug allergies that are identified should be displayed **prominently** in a specific location location on the outside of the patient's chart as well as on the medication control record.

Summary

The information provided in this article should not be construed as all encompassing. It is not intended to be legal advice. It is intended to be a risk management presentation of certain aspects of claims data, treands, systems and processes in order to better equip physicians and office personnel in recognizing, preventing and controlling medication-related incidents.

For more risk management information or assistance, please contact me at Medical Assurance, (304) 522-0601 or FAX (304) 522-0602.

Plan Now To Attend!

Medical Assurance of West Virginia's Loss Control Seminar

"Communicate Your Way to Effective Patient Relationships"

Featuring

Jerry Patterson, Ph.D. and Don Sensabaugh, J.D.

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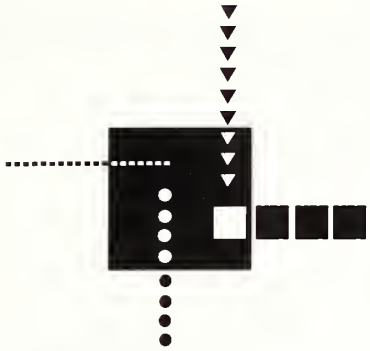

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A case of cervical lymph node metastasis resulting from glioblastoma multiforme

CHINMAY K. DATTA, M.D., PH.D.
Pathologist

JAMES D. WEINSTEIN, M.D.
Neurosurgeon

JAMES E. BLAND, M.D.
Otolaryngologist

PAUL M. BRAGER, M.D.
Oncologist

MICHAEL A. STEWART, M.D.
Radiation Oncologist

United Hospital Center, Clarksburg

Abstract

This article presents a rare case of metastatic glioblastoma multiforme (GM) to the cervical lymph node. In spite of very aggressive tumor behavior, extracranial metastasis from intra- cerebral GM is rare. Only a few cases are reported in the world literature. This infrequent extracranial metastasis may be due to the fact that patients do not live long enough to manifest metastases or result from the fact that brain tissue has some structural differences from other tissues in the body. This tumor can be easily mistaken for other anaplastic tumors like malignant melanoma, malignant lymphoma, or anaplastic carcinoma. Positive glial fibrillary acidic (GFA) protein stain (an immunoperoxidase stain) of this metastatic tumor can eliminate all other time consuming, expensive, and exhausting procedures for the patient.

Introduction

GM is a highly malignant tumor of the central nervous system (CNS). This disease has a very poor prognosis with 90% of patients dying within two years of its onset.

This pleomorphic tumor is considered a Grade IV tumor of the astrocytic group of neuroglial cells. GM is a distinct entity differentiated from anaplastic (malignant) astrocytoma by the presence of vascular endothelial proliferations and/or necrosis. Anaplastic (malignant) astrocytoma is considered as a Grade III tumor of the astrocytic group of neuroglial cells.

In spite of its very aggressive growth and poor prognosis, extracranial metastasis from GM is extremely rare. Under routine histological stains, this tumor can be difficult to differentiate from other anaplastic tumors of non-CNS origins. Positive glial fibrillary acidic (GFA) protein stain will make a definite diagnosis of GM.

Case report

A 35-year-old woman had been experiencing headaches for almost nine months before she saw her physician in September 1996. A CT scan was performed which showed a large mass at her right parietal lobe.

She underwent a craniectomy with debulking of the tumor which was necrotic. Microscopically, the tumor showed marked pleomorphism of the tumor cells with areas of necrosis, pseudopalisading arrangements, and extensive vascular endothelial proliferations (Figure 1). The diagnosis of GM was rendered.

This patient received two cycles of continuous infusion of Cisplastin and BCNU, as well as whole brain radiation. She did fairly well until April 1997 when she developed a severe headache. She underwent another craniectomy with debulking of the tumor. At that time, CT scan of the neck showed a 3 cm soft tissue mass in the right neck (Figure 2).

Biopsy of the lymph node showed an anaplastic tumor with extensive necrosis and marked pleomorphism of the tumor cells (Figure 3). Immunoperoxidase stains were performed which included leukocyte common antigen (LCA), epithelial membrane antigen (EMA), cytokeratin, S100, HMB-45, and GFA protein. GFA protein stain was strongly positive (Figure 4) which supported the diagnosis of metastatic GM. All other stains were negative.

This patient died in July 1997.

Discussion

Tumors of the astrocytic group of neuroglial cells are classified by the World Health Organization (1) as:

Astrocytoma (Grade II)
Variants: fibrillary, protoplasmic, and gemistocytic

Anaplastic (malignant) astrocytoma (Grade III)

Glioblastoma multiforme (Grade IV)
Variants: Giant cell glioblastoma and gliosarcoma

Pilocytic astrocytoma (Grade I)

Pleomorphic xanthoastrocytoma (Grade II)

Subependymal giant cell astrocytoma (Tuberous sclerosis) (Grade I)

Among all the glial tumors, GM is a distinct entity and the most aggressive tumor. It is composed of markedly pleomorphic tumor cells including giant and multinucleated forms. Vascular endothelial proliferations and/or necrosis are the two pathognomonic features in the diagnosis of GM (1). These features are absent in Grade III anaplastic (malignant) astrocytoma which are considered as the differentiating points between these two tumors (1). Neoplastic astrocytic cells can be seen around necrotic areas which are known as pseudopalisading arrangements.

GM represents 15%-20% of all intracranial tumors and accounts for 50% of cerebral gliomas (2). The peak incidence is between the ages 45 and 55 and occurs predominantly in males (2). Frontal lobe of the cerebral cortex is most often involved, but it can occupy more than one lobe (2). The 'butterfly' pattern on coronal sections of cerebral cortex showing tumors on both sides of the hemispheres through corpus callosum is highly characteristic and can also be identified on X-ray.

The clinical manifestations of GM are similar to other intracranial tumors. However, the onset of GM is very acute and progresses very rapidly. In general, 90% of patients die within two years from the onset of the disease (2) even after extensive surgery followed by chemotherapy and radiation. In rare instances, some patients have survived for more than two years (2), but it has been stated that some of these reported cases may not represent GM. One example is pleomorphic xanthoastrocytoma which can be easily confused with GM (2).

GM can spread within the CNS and invade the meninges and spinal cord. However, extracranial metastasis of this is extremely rare (2-9). Most cases reported in the literature occurred after surgical interventions. Our patient falls in the same category.

Why do GMs metastasize extracranially so infrequently? It is possible that many factors like impassable dura, thick basement membrane of intracerebral blood

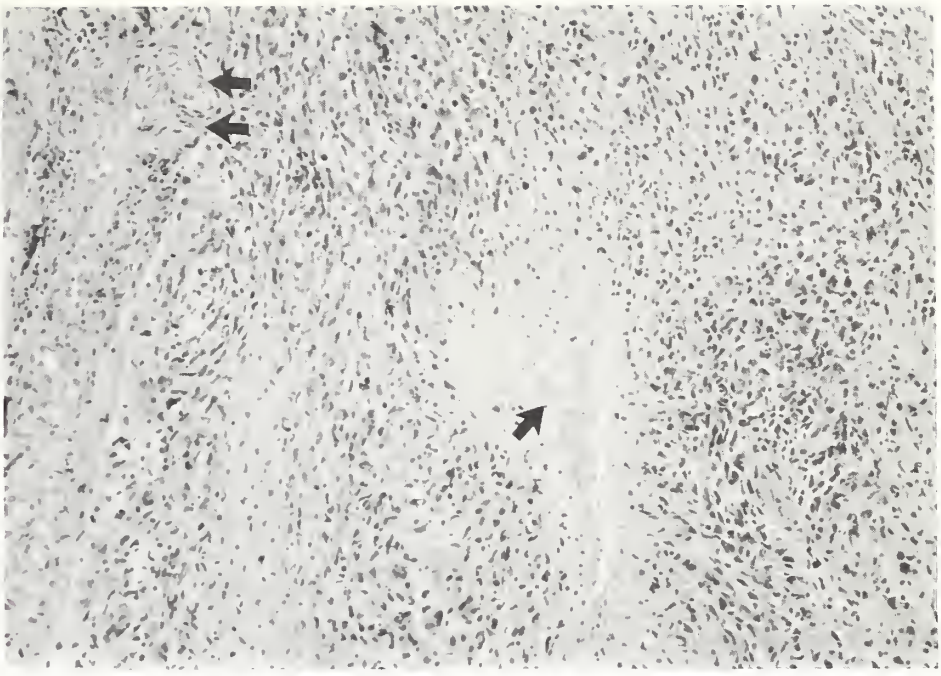

Figure 1. Glioblastoma multiforme in right parietal lobe of cerebral cortex showing necrosis (arrow), vascular endothelial proliferations (double arrows), and pleomorphism of the nuclei.

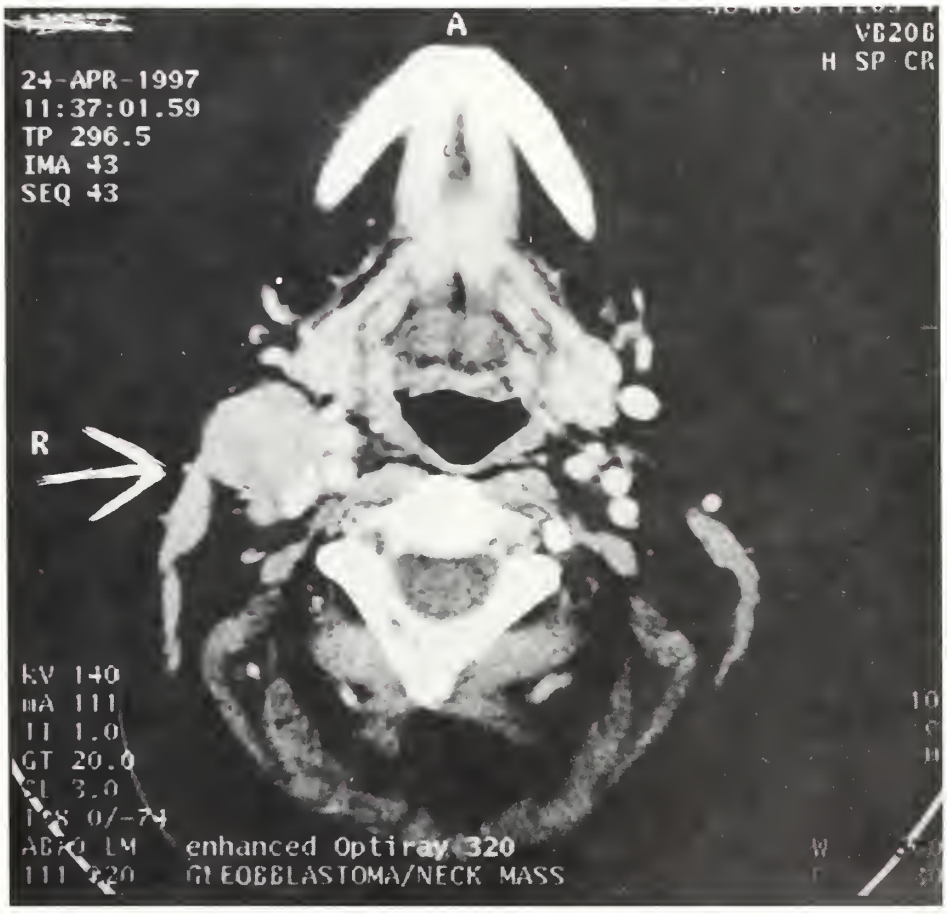

Figure 2. CT scan showing a soft tissue mass in the right neck (thick white arrow).

vessels, and lack of lymphatic system in the brain are responsible for infrequent metastasis (6). It occurs when these barriers are broken by the surgical interventions (2). The most common sites for metastasis are lung, pleura (3,9), liver, mediastinal and cervical lymph nodes, and bone (6-9).

This tumor when it metastasizes can be easily mistaken for other non-CNS anaplastic tumors like malignant melanoma, malignant lymphoma, and anaplastic carcinoma. It is very important to perform GFA protein stain, an immunoperoxidase stain, when metastatic GM is suspected. Negative stain excludes the diagnosis of GM.

Conclusion

An extremely rare case of metastic GM in the cervical lymph node is presented along with a review of the literature. This metastatic tumor can be easily mistaken for other anaplastic tumors of non-CNS origin. GFA protein stain will eliminate this confusion so that patients do not have to go through all other time consuming, expensive, and exhausting procedures.

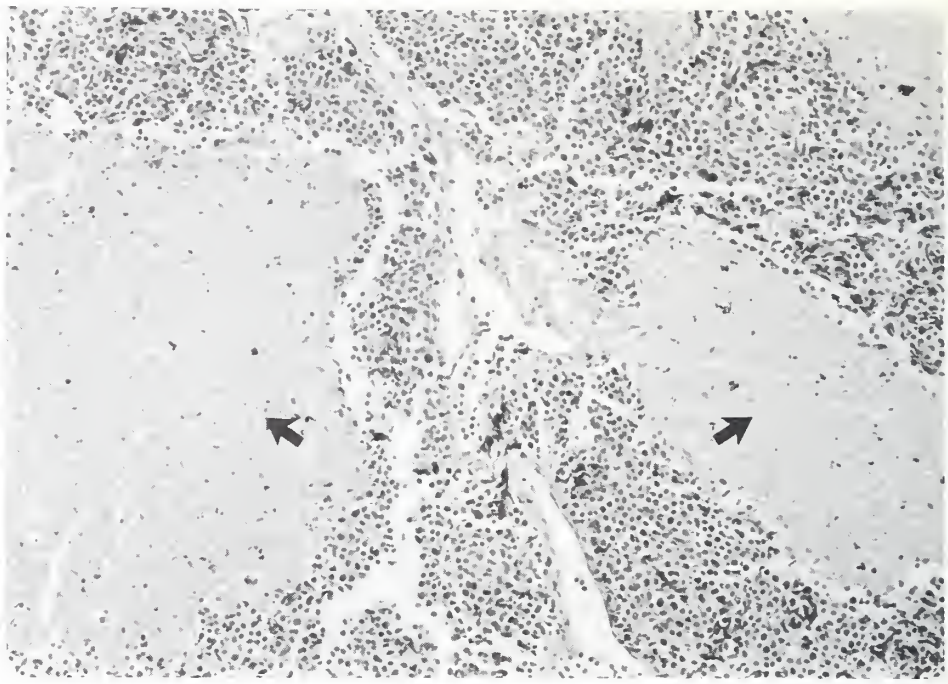

Figure 3. Glioblastoma multiforme in the right neck showing extensive necrosis (arrows) and marked pleomorphism of the nuclei.

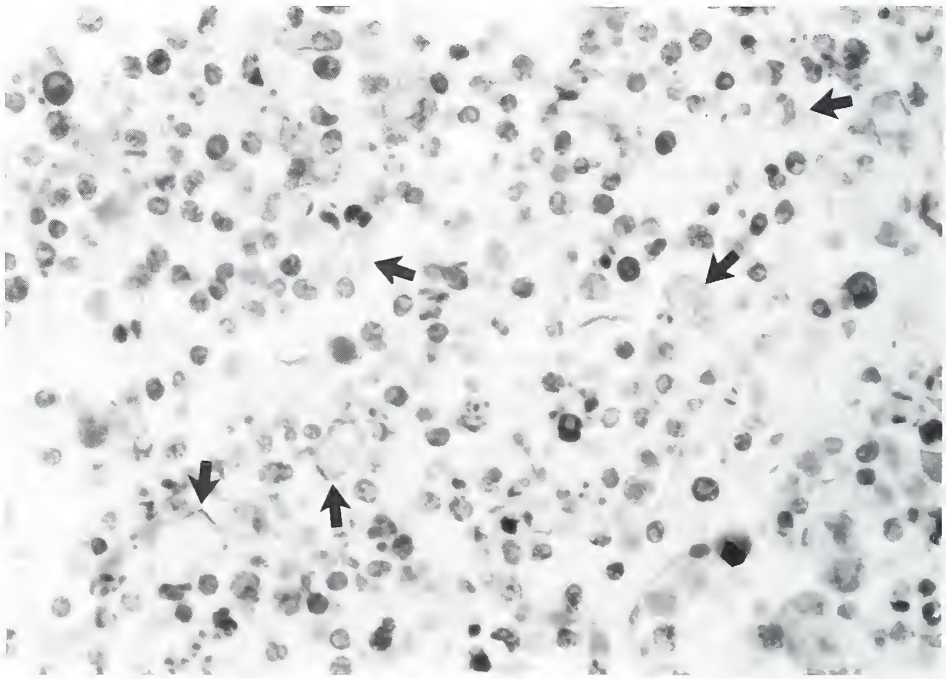

Figure 4. Right neck tumor showing strongly positive glial fibrillary acidic (GFA) protein stain (arrows).

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A survey of pediatric malignancy in West Virginia

FRANK G. KELLER, M.D.
Associate Professor, Department of Pediatrics, Division of Hematology/Oncology, Robert C. Byrd Health Sciences Center, Morgantown

KENNETH A. STARLING, M.D.
Professor, Department of Pediatrics, Division of Hematology/Oncology, Robert C. Byrd Health Sciences Center, Charleston

JANE MARTIN, R.N., P.N.P.
Department of Pediatrics, Division of Hematology/Oncology, Robert C. Byrd Health Sciences Center, Charleston

JENNIFER DEFAZIO, R.N.
Department of Pediatrics, Division of Hematology/Oncology, Robert C. Byrd Health Sciences Center, Morgantown

M.E. STEINER, M.D.
Department of Pediatrics, Division of Hematology/Oncology, Robert C. Byrd Health Sciences Center, Morgantown

A. KIM RITCHEY, M.D.
Professor, Department of Pediatrics, Division of Hematology/Oncology, Robert C. Byrd Health Sciences Center, Morgantown

Abstract

The occurrence of malignancy in the pediatric age group is an uncommon but serious event. Since little data are available on the extent, nature or referral patterns of childhood cancer in West Virginia, we conducted a survey of 782 primary care physicians and 17 regional referral centers. The results showed that 249 cases of malignancy in the pediatric age group were reported and that 68% of children with newly diagnosed childhood malignancy were referred to institutions within West Virginia. We conclude that the incidence and distribution of types of malignancy in childhood in West Virginia parallels that of the nation, although there is some regional variation within the state.

Introduction

Despite tremendous advances in diagnosis and treatment, cancer is second only to accidental injury as a cause of death in the pediatric age range, and remains the most common fatal disease during childhood (1).

The nature of pediatric malignancy differs substantially from adult cancers, and the overall survival is significantly better for children than for adults with cancer (2). This is fortuitous since the potential years of life saved is greatest for the youngest victims of these diseases. Although the frequency of childhood cancer is small when compared to all cancers, it is disproportionately important, since it is estimated that 1 in 750 young adults will be cancer survivors by the year 2010 (2).

The most comprehensive cancer statistics in the United States are maintained by the Surveillance, Epidemiology and End Results (SEER) Program of the National Cancer Institute. The SEER data are derived from five states and four metropolitan areas and are felt to be representative of national cancer incidence and outcome. There are no published data regarding the incidence of childhood malignancy in West Virginia.

In order to determine whether there were any significant differences within West Virginia in the incidence and distribution of cancer in childhood, as well as to determine physician referral patterns for pediatric malignancy, a survey of primary care physicians and regional referral centers was undertaken.

Methods

Survey forms were mailed to 782 primary care physicians (pediatricians and family practitioners) within West Virginia and surrounding regions, asking for a report of any child diagnosed with a malignancy during the five-year period from 1990-1994. In addition, surveys were sent to 17 regional academic institutions which offer expertise in the diagnosis and management of pediatric malignancy.

Eligibility criteria for inclusion in the study were residency in West Virginia, age less than 19 years at the time of diagnosis, and diagnosis during the years 1990 through 1994. Patient initials, age, diagnosis, and referral patterns were used to avoid duplication of data.

The incidence of pediatric malignancy in children 14 or younger for the state as a whole and for individual counties was compared to the national incidence rate using Poisson distributions. National incidence rates were obtained from the SEER Cancer Statistics (3). Population and demographic data were obtained from the Vital Health Statistics of West Virginia 1993 (4).

Results

One hundred thirty primary care providers (17%) responded to the survey. Responses were also received from 14 regional referral centers, yielding a response rate of 74%.

A total of 249 cases of malignancy were identified in children 18 years of age or less in West Virginia during the five-year period, a rate of approximately 50 new cases of pediatric malignancy per year. The frequency of cases reported in older adolescents was less than for younger children, perhaps reflecting a greater tendency to refer these patients to "adult" oncology programs. Therefore, statistical analysis was restricted to children 14 years of age or less.

The annual incidence of malignancy in the 0-14 age range for the years surveyed was 11.8 new cases per 100,000 persons. This was not statistically different from the national incidence of 13.9 cases per 100,000 persons ($p = 0.677$). Figure 1 compares the incidence figures for West Virginia to that derived from the SEER data for different age groups and shows they are similar.

Figure 2 demonstrates the distribution of the reported cases of pediatric malignancy among the most common forms of malignancy in the 0-14 year age group, compared to the SEER data. There was remarkable similarity in the distribution of type of malignancy between our results and the national data.

The number of reported cases per county of residence is shown in Figure 3a. No cases of pediatric malignancy were reported in 11 counties. In general the greatest number of cases came from the counties with the largest population of children, however, there was some variability in the incidence across the state as shown in Figure 3b. Only Randolph County was found to have a statistically significant increased incidence of malignancy in children 14 years of age or less ($p = 0.0156$) when compared to the national rate. Grant County's higher incidence rate was less statistically certain due to its small population. The combined results of three counties of the Potomac Highlands (Tucker, Grant and Randolph) also reached a statistically significant difference from national data (33.09/100,000, $p = 0.0022$.)

Sixty-eight percent of patients were initially referred to multidisciplinary pediatric oncology programs in West Virginia. The majority of the remaining patients were referred to centers in surrounding states which were geographically close to their residence. A small minority of patients were apparently initially referred to more distant institutions.

Discussion

This study confirms that the incidence and distribution of pediatric malignancies within West Virginia were similar to national data during the five-year interval of the survey. While it is not possible to determine whether there is an increasing incidence of pediatric malignancy in West Virginia based upon this study, there has been a well documented gradual increase

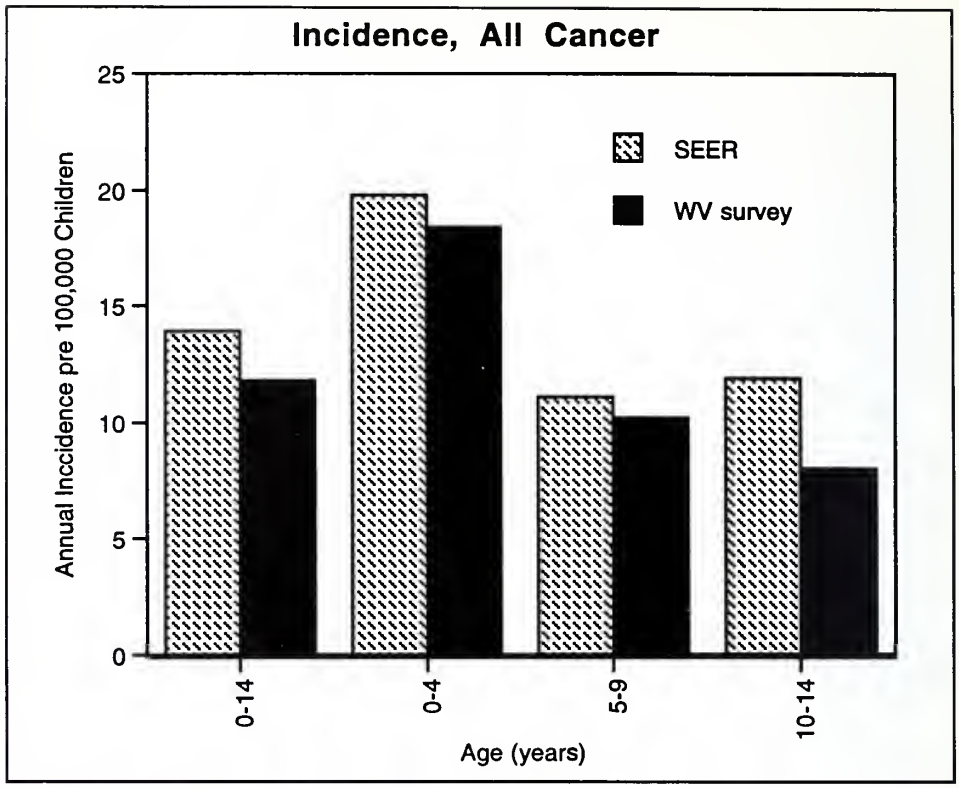

Figure 1. **Incidence of pediatric malignancy in West Virginia and nationally as reflected in SEER data.**

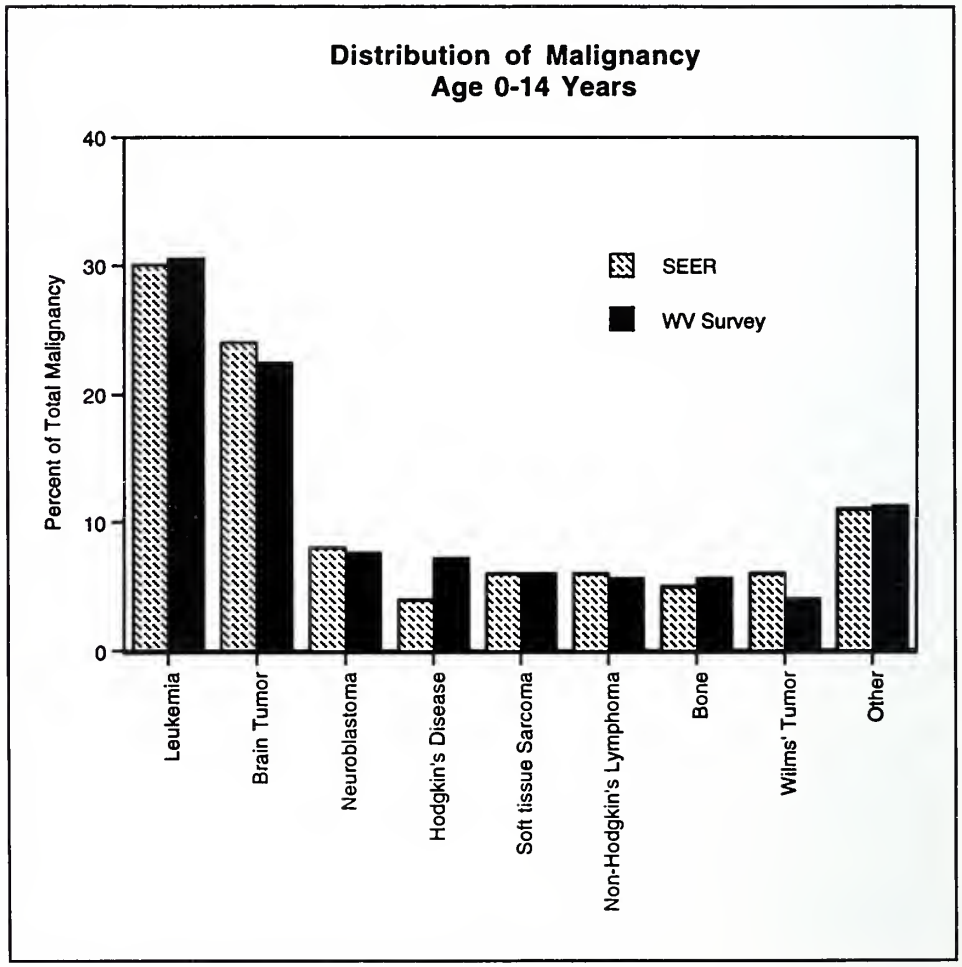

Figure 2. **Distribution of pediatric malignancy in West Virginia and U.S.**

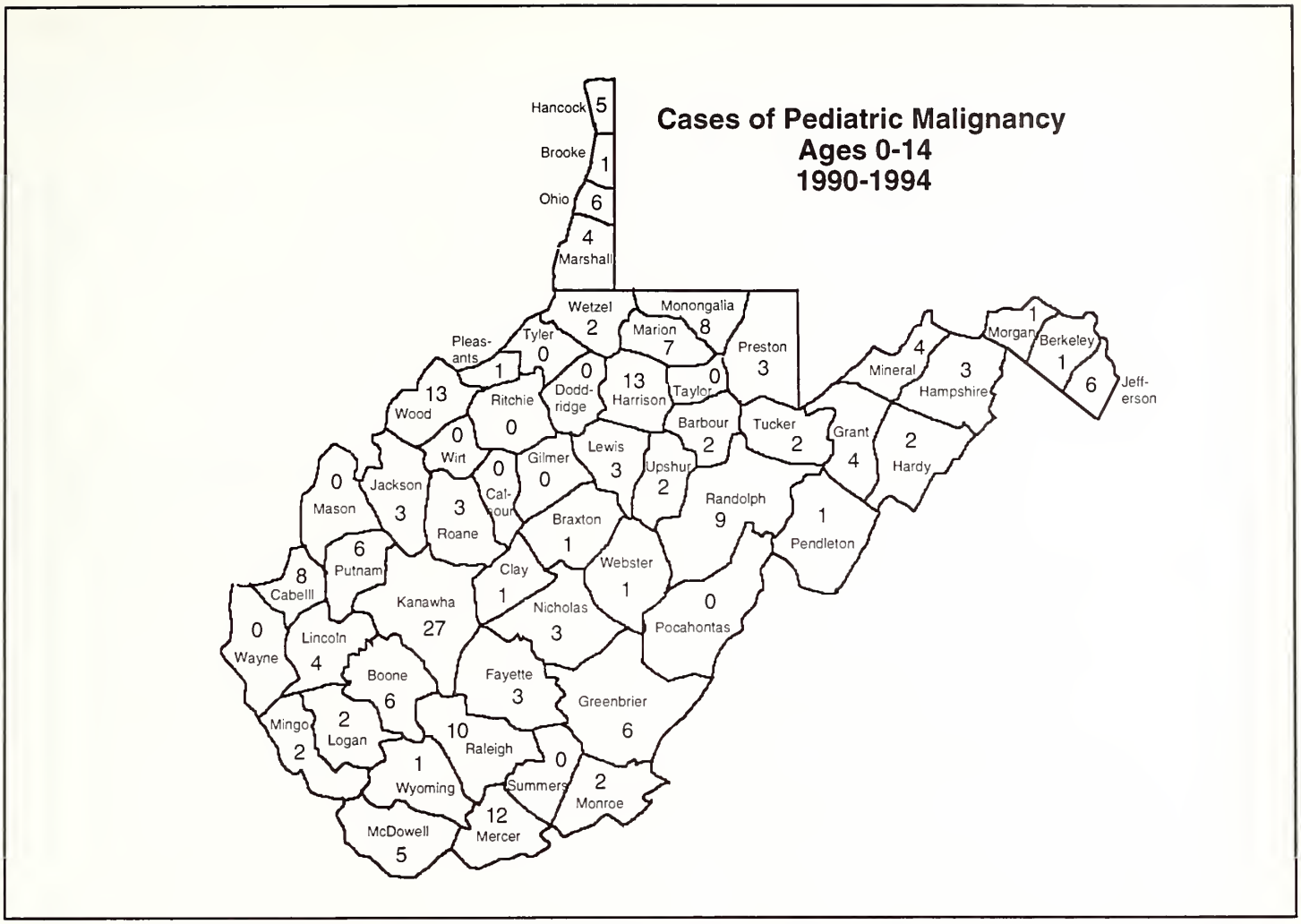

Figure 3a. **Number of reported cases of cancer in children 14 years or less within each county in West Virginia.**

nationally (3). The recently established state cancer registry may be helpful in tracking the incidence of childhood malignancy over time.

Regional variation in the incidence rates must be interpreted with caution, despite achievement of statistical significance. The etiology of cancer during childhood is not completely understood, and may include complex interactions of genetic and environmental factors (5), making it extremely difficult to implicate any single factor as etiologic. In addition, malignancy in the areas of highest incidence did not conform to a predominant type, but were distributed over several forms of childhood cancer. Finally, the defined nature of the survey over a relatively short time period, and the small number of cases, increases the likelihood that the apparent increased incidence may not persist over longer time intervals. Continued monitoring of the areas in question is warranted.

The majority of children with malignancy were initially referred to centers within West Virginia. These illnesses often require complex management best supevised by health care providers with expertise in childhood cancer, including oncology nurses, oncologists, pediatric surgical specialists, radiation oncologists, social workers, research associates and others. The opportunity to participate in current national state-of-the-art investigational protocols remains the standard of care for children with cancer. Such clinical trials have been shown to improve the overall survival of children facing these difficult diseases, while advancing scientific knowledge about the disease and its treatment (6). Pediatric referral centers in West Virginia offer special expertise in childhood cancer management and participate in national cooperative group clinical trials for many different forms of malignancy which occur in childhood and adolescence.

Acknowledgements

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In addition, we would like to express our special thanks to Patti Wright and Paula Nicholson for collating and mailing all of the surveys utilized for this study.

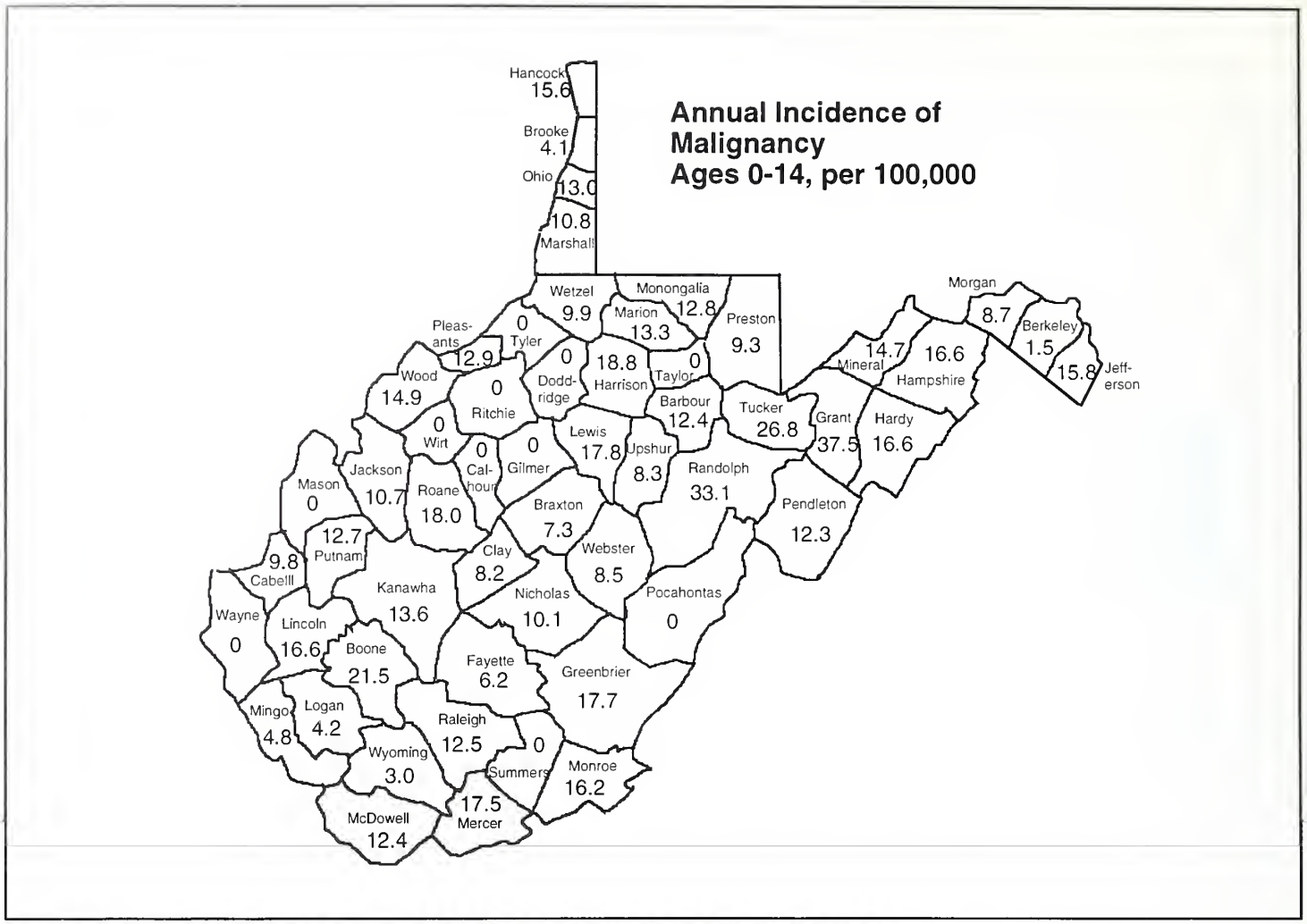

Figure 3b. **Incidence rates per 100,000 children during the survey period.**

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Tonic clonic seizures and tachycardia induced by fluoxetine (Prozac[R]) overdose

JEFFREY L. NEELY, M.D.
Professor of Medicine, Department of Medicine, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown

Abstract

Use of the serotonin uptake antidepressants is growing. These agents are thought to be safer than the tricyclic antidepressants, but clinicians should be aware that with overdoses, seizure activity and cardiac dysrhythmias have been reported in the medical literature. Physicians should be prepared to recognize and manage these overdosages. An illustrative case and a review of the literature are presented.

Case report

An 18-year-old male was found by his roommate in full tonic-clonic seizure of unknown duration; the EMS technician noted an empty bottle of fluoxetine at his bedside.

It was revealed that this patient had become despondent after an argument with some friends and subsequently called his psychiatrist and asked for a refill of his fluoxetine. He had told his physician that his HMO required that he receive a 90-day supply of the medicine. He then took 120 tablets of 20 mg fluoxetine (total 2440 mg) with an unknown quantity of beer approximately eight hours before the seizure activity had begun.

Upon arrival in the Emergency Department approximately 40 minutes later, he was noted to have a diminished level of consciousness. Vital signs showed a temperature of 36.9^0 oral, tachycardia at a rate of 130/min and respiratory rate of 24/min. BP was 170/80 mmHg. There were no signs of trauma. Pupils showed symmetrical reactivity. Fundoscopic exam revealed flat discs. Typanic membranes were normal. The oropharynx was unremarkable but the lips showed dried blood. The patient's neck was supple with no lymphadenopathy. The lungs were clear to auscultation.

The cardiac exam showed a regular tachycardia but no murmur or gallop. The abdomen was flat and muscular without evidence of trauma. There were normal bowel sounds and no masses or tenderness of the abdomen were noted. There were normal bowel sounds and no masses or tenderness of the abdomen were noted. Neurologic exam was normal except for the diminished level of consciousness. An ECG showed sinus tachycardia with an intraventricular conduction delay that resolved the following day.

This patient was placed in an observation area of the ED. Blood samples and urine drug screen were obtained. Since he was continuing to have a decreased level of consciousness and vomiting, the patient was electively intubated. He was taken to Radiology for a CT scan of his head which showed no intracranial mass, bleeding, or trauma.

While in the ED, he suffered further tonic-clonic seizure activity (for 10-12 minutes) which was treated with IV diazepam (Valium[R]). He was placed on a ventilator and admitted to the MICU. The following tests were obtained: CXR normal; ECG revealed sinus tachycardia with no evidence of ectopy or ischemia; sodium 154; potassium 5.1; chloride 110; bicarbonate 13; BUN 7; creatine 1.3; glucose 152 WBC 12,500; hemoglobin 18.5 grams; hematocrit 54%, platelet count 439,000; alkaline phosphatase 123; LDH mildly elevated at 778, total bilirubin normal at 1.1, SGOT 37, SGPT 31 and gamma GT 23. Serum drug screen was returned without evidence of acetaminophen, barbitartates, benzodiazepines, alcohol, salicylates, or tricyclics. Fluoxetine levels were not obtained.

He was given charcoal and sorbitol and aggressive IV fluids and stabilized in the MICU. The following day, he was extubated and transferred to a medical floor. No further seizure activity was seen.

Discussion

The serotonin uptake inhibitors were developed and marketed not only for their increased efficacy, but also for their low side-effect profile and a limited morbidity and mortality.

Fluoxetine is a noncyclic antidepressant introduced in 1988 (1). It selectively inhibits presynaptic reuptake of serotonin, increasing the

synaptic concentration of serotonin, thereby facilitating serotonergic neurotransmission. It is thought to have little effect on norepinephrine and dopamine uptake.

The exact mechanism whereby fluoxetine improves symptoms of depression is not known. After being easily absorbed, the drug has a long elimination half life of 1 to 3 days after short-term administration and 4 to 6 days after long-term administration. It is extensively metabolized in the liver to its metabolite norfluoxetine, which has an even longer elimination half-life than the parent compound (2).

Fluoxetine is thought to be a safe antidepressant, but there is a small and growing body of literature describing the clinical effects of overdosage. Since depressed patients may use an overdose in a suicide attempt, clinicians must be aware of this clinical course. Therapeutic doses of fluoxetine are associated with fewer anticholinergic side effects than the tricyclic antidepressants, but nervousness, insomnia and nausea are frequently reported (3,4). Five fatalities from fluoxetine overdose have been reported (5).

In the largest number of fluoxetine overdose cases reported from four poison control centers, 67 adults ingested a maximum dose of 1500 mg. Thirty (45%) of these adults remained asymptomatic. The most common symptoms reported were tachcardia, drowsiness, nausea and vomiting (5). The patient described in this article had these symptoms, as well as seizure activity.

Cardiovascular effects

With overdoses of the older tricyclics, cardiac dysrhythmias have been a major concern with much of the morbidity and mortality of these overdoses stemming from the cardiac dysrhythmias; the side effect profile of fluoxetine has been considered safer than tricyclic antidepressants from a cardiovascular standpoint (4).

The case presented demonstrates a persistent sinus tachycardia with a rate of 130. Fluoxetine has a selectivity for serotonin receptors which results in a very decreased anticholinergic or cardiovascular effect (6). Eli Lilly and Company, which manufactures fluoxetine, reports a low incidence of fluoxetine-related cardiovascular complications including tachycardia, syncope, palpitations, hypotension, ventricular tachycardia and supraventricular tachycardia (6,7). In therapeutic doses, the literature has reported bradycardia and syncope in two patients and symptomatic supraventricular tachycardia in one patient (7).

Roberge (6) described cardiovascular complications of overdoses of fluoxetine from several poison control centers. In a series of 214 patients, six of 41 patients with serum fluoxetine levels available experienced tachycardia, but no other ECG abnormalities (6). Other investigators have reported junctional rhythms, ST-segment depressions and prominent U waves in fluoxetine overdoses. Borys (5), in the largest study on fluoxetine overdose, concluded that minimal toxicity (sinus tachycardia, trigeminy and junctional rhythm) occurs when up to 1550 mg of fluoxetine is ingested (5). The cardiovascular complications are thought to be vagally mediated as evidenced by hypotension and syncope (6).

Seizures

In the premarketing trials reported by Wernicke (4), four of 1,378 patients evaluated were reported to have had possible seizures in three of the four patients. Cooper (3) found only three definite seizures of 2,938 patients studies who were taking therapeutic doses of fluoxetine.

Braitberg (8) summarized seven case reports describing seizure activity in patients taking therapeutic doses of fluoxetine. In each of these reports, the direct correlation of seizure activity with the use fluoxetine is not well defined; each case had other possible predisposing conditions for seizure activity. In their review of the use of fluoxetine in the elderly, Harris and Benfield (2) noted only one case of a patient having seizure activity while on therapeutic doses of fluoxetine and this patient was actually receiving concomitant electroconvulsive therapy.

Very few reports have appeared in the literature to support a causal role of fluoxetine and seizure activity in fluoxetine overdoses. In the largest number of fluoxetine overdoses reviewed in the literature, Borys (5) reviewed over 200 cases and discovered no reports of seizure activity. In reporting the manufacturer's clinical trials, Wernicke cited only one case of seizure activity in a patient who ingested 3,000 mg of fluoxetine (4). The patient had two brief seizures nine hours after the ingestion and a fluoxetine level of 2,461 ug/L at the time of the seizure activity. Other possible predisposing factors or other seizure inducing medications were not reported.

Riddle (9) reported one case of fluoxetine overdose in an adolescent that had documented increased serum levels. However, this patient had previous neurologic problems including Tourette syndrome and haloperidol-induced tardive dyskinesia; other ingestants were not ruled out. Levine (10) described seven cases of seizure activity that occurred when fluoxetine was used, but all were used under proconvulsant conditions (e.g. drug withdrawal, hyponatremia).

In the most recent case, Braitberg reported that a 15-year-old girl with a history of depression experienced witnessed tonic-clonic seizure activity after taking 900 mg of fluoxetine (8). Quantitative fluoxetine and norfluoxetine levels assayed 12 hours after ingestion revealed a fluoxetine level of 1,956 ng/ml (normal, 47 to 469 ng/ml) and a norfluoxetine level of 416 ng/ml (normal, 52 to 466 ng/ml). No other ingestants were identified. This patient had an uneventful 24-hour hospital course. Long-term follow-up indicated that she had no further seizure activity.

Conclusion

In summary, this article reports a case of seizure activity associated with a large overdose of fluoxetine. No other predisposing factors for seizures were identified.

There is now widespread use of the serotonin uptake inhibitors and more overdosages can be anticipated. Physicians should be alert for these symptoms; clinical laboratories should be prepared to screen for these drugs and be able to measure levels. Clinicians should be cautious in prescribing fluoxetine in patients who have unstable epilepsy or are predisposed to seizure activity. Due to the long half-life of fluoxetine and demonstrated toxicity at higher doses, in-hospital observation is indicated.

Physicians should also be wary of prescribing larger amounts of these medications despite pressure and guidelines from the managed care or pharmacy industries.

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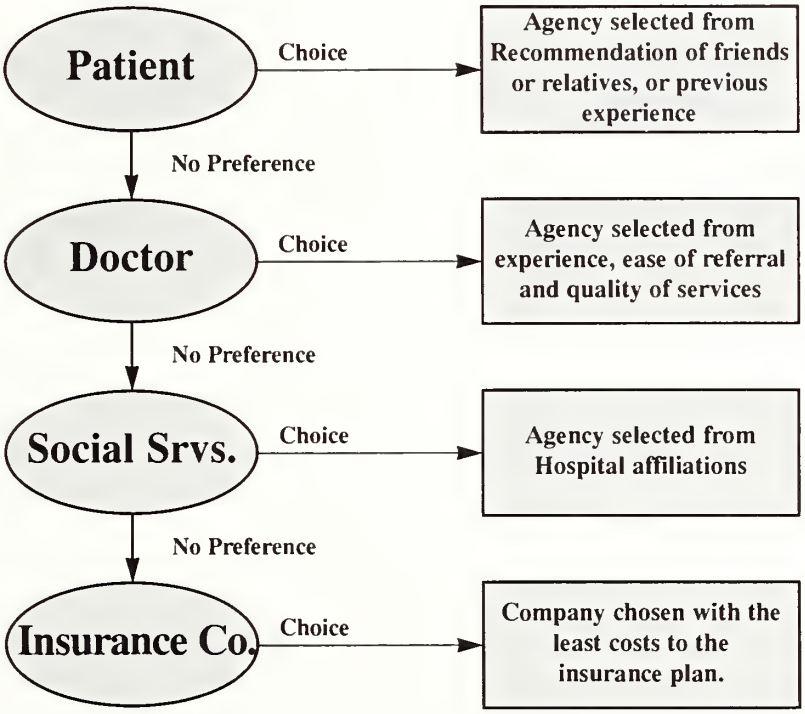
Healthcare — Who's Choice is it?



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Legislative Reception to kick off Mid-Winter Clinical Conference at Embassy Suites

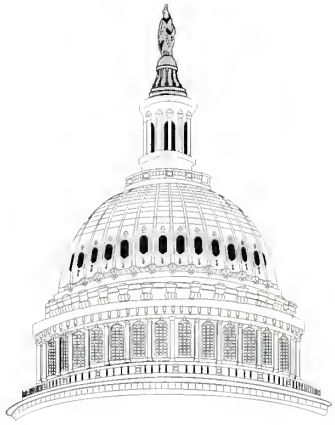
Charleston's new Embassy Suites will be the setting for both this year's WVSMA Mid-Winter Clinical Conference from January 21-24, and the WVSMA's Legislative Reception, which is scheduled for Thursday, January 21 at 6:30 p.m. in conjunction with the conference.

In addition to the Legislative Reception, four scientific sessions, a a Lunch & Learn, a Physician/Public Session, a loss control seminar, the WVSMA's Medical Student Section's Annual Meeting, and a variety of business and social events are again planned for the WVSMA's Mid-Winter Clinical Conference. A CME workshop and other activities are also being discussed for the meeting.

The First Scientific Session on Friday, January 22 at 1 p.m. will feature lectures on impotence, Hepatitis A, B and C, hypertension and abnormal pap smears. That evening, Cindy W. Christian, M.D., of the University of Pennsylvania School of Medicine, will take part in a panel discussion about violence and family abuse issues for the Physician/Public Session. Dr. Christian will also present a Lunch & Learn program the next day on the effects of child abuse and neglect.

On Saturday, lectures for the Second Scientific Session at 9 a.m. will revolve around controversies regarding *"Antibiotic Treatment of Acute Pediatric Otitis Media"* and *"Alternative Medicine."* Following the Lunch & Learn at noon, the meeting will reconvene at 1:30 p.m., with the Third Scientific Session on end-of-life care. This session was highlighted in the July/August issue of the *Journal* and will include the following four presentations:

Mid-Winter Clinical Conference
Embassy Suites, Charleston, W.Va.
January 21 - 24, 1999



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"Palliative Care: A Moral Mandate for All Physicians," by Alvin H. Moss, M.D.; *"When Is a Patient Dying: What Does the Medical Literature Say?"* by Sue Warren, M.D., F.A.C.P.; *"Patient-Centered Pain Management at the End-of-Life"* by Timothy Deer, M.D.; and *"The Ethics of Eating, Feeding and Sedating at the End-of-Life"* by Jacqueline J. Glover, Ph.D. After these lectures, the four speakers will conduct a case presentation and panel discussion entitled *"Dilaudid Did Not Touch Her Pain."*

The conference will conclude on Sunday after the Fourth Scientific Session, which will feature a lecture on *"Image-Guided Breast Biopsies"* by Margaret Kemeny, M.D. of Manhasset, N.Y., and the popular Stump the Audience segment facilitated by Drs. Robert J. Marshall and Warren Point, M.D.

Further meeting details can be obtained by phoning the WVSMA at (304) 925-0342, or turn to page 269 for a registration form. To phone the Embassy Suites for room reservations, dial 1-800 Embassy or 347-8700.

Plans set for 12th Annual FP/Sports Medicine Weekend

Over 1,300 health care professionals, exhibitors and family members are expected to attend the 12th Annual Family Practice Weekend & Sports Medicine Conference, Nov. 20-22, at the Radisson Hotel in Huntington.

Lectures at the meeting will include *"Diabetic Response to Exercise," "Exercise in Chronic Illness," "Exercise in Pregnancy;" "The Female Athlete;" "Injuries in Hockey;" "Adolescent and Pre-Adolescent Weight Training;" "Overuse Injuries;" "General Principles of Rehabilitation; "Anticonvulsants: Current Applications in Neurological Conditions," "Cardiovascular Risk Factor Management;" "Impotence;" "Treatment of Mental Disorders in Primary Care;" "Quinolones-Antibacterials-Microbiology-Pharmacology and Clinical Woes;" "Respiratory Tract Concerns;" "Emerging Antimicrobial Resistance Implications for Diagnosis and Treatment;" "Sleep, Anxiety and Depression;" Cholesterol and MI Prevention;" "Hypertension: Advancements in Treatment:" and Endocrinology and Women's Health."*

Martinez

Ryan

Cadieux

Faculty will feature a number of nationally recognized speakers such as Dr. Jose Martinez of the Watson Clinic in Lakeland, Fla., Drs. Neil Ellison and Michael Ryan of the Penn State Geisinger Health System in Danville, Pa.; Dr. Robert Rapp of the University of Kentucky; Dr. Roger Cadieux of the Department of Psychiatry at Penn State University College of Medicine; and Dr. David Trinkle from the University of Virginia. The sports celebrity at this year's meeting will be Matt Ghaffari, a silver medalist in heavyweight wrestling at the 1996 Olympic Games in Atlanta, who will discuss *"Sports-Related Health Problems Experienced by Professional Athletes."*

Other conference highlights will include a fund-raising party for the Family Medicine Foundation in conjunction with the Huntington Blizzard's hockey game, and a reception and tour of the Touma Museum of Medicine.

For more information, phone Chris Ferrell at (304) 765-7839.

Problems with managed care increasing in WV, nation

According to George Rider, the executive director of the WVSMA, and Nidia Henderson, director of government relations for the WVSMA, a number of physicians have recently phoned the WVSMA to discuss problems with managed care companies in the state.

Some of the complaints received are as follows:

- A pediatrician was terminated from participating in a Health Maintenance Organization (HMO) after this company cited him for failing to discuss advance directives with his patients.
- Anesthesiologists have been forced into a "take it or leave it payment status" by HMOs exploiting the WV Code which permits physicians no recourse.
- HMOs are engaging in "peer review" by nameless and faceless individuals who sit in judgment of physicians, but do not permit them their day in court.
- Health care "networks" are lobbying the state for Medicaid and PEIA contracts assuring that they will save the state money by penalizing physicians who refer patients to specialists.

"Across the country, HMOs lost over $768 million in 1997, part of a three-year negative trend," Rider said. "Congress is now investigating HMOs because about 33 of the 347 HMOs participating with Medicare have announced they will be terminating their contracts.

"Where Medicaid is concerned, three of the largest for-profit plans, PacificCare Health Systems, Aetna U.S. Healthcare and Oxford, have also announced they are pulling out of Medicaid. It is evident that HMOs are just concerned with making money by the recent revelation that three out of the four HMOs serving Medicaid patients in Mississippi are only spending about 66 percent of their revenues on patient care."

Henderson added that a recent survey of U.S. physicians indicates that many doctors feel compelled to engage in what is newly coined as "conscience-driven deception," i.e. dishonesty used to gain patients the care they need.

Rider and Henderson are encouraging physicians who have complaints to phone them at the WVSMA at (304) 925-0342.

Dr. Skaff named chief of staff at CAMC

Skaff

Paul A. Skaff, M.D., an anesthesiologist affiliated with General Anesthesia Services, Inc., has assumed Dr. Shawn Chillag's role as chief of staff at Charleston Area Medical Center. Dr. Chillag has resigned to join Greenville Hospital Systems in Greenville, S.C.

Dr. Skaff was chosen chief of staff-elect for 1998 by members of CAMC's active medical staff last November. In this role, he would have automatically become chief of staff in 1999.

Participants wanted for Centenarian sibling pair study

The Harvard Medical School and the Beth Israel Deaconess Medical Center, both of Boston, are seeking participants for a genetic study on aging to help discover information that could lead to a cure for diseases for as Alzheimer's disease and cancer.

Subject candidates should be 98 years old and older whose living brothers and sisters are at least 90. Participants DO NOT have to live in the Boston area. Participation is voluntary and free of charge.

Physicians are encouraged to refer any patients who may qualify.

For more information, phone 1-888-333-6327.

On November 3

VOTE!!!

Kanawha Hospice annual meeting set

"How to Support the Dying Person: What to Say, What to Do" is the title of Kanawha Hospice Care's Sixth Annual Hospice and Palliative Care Conference which will take place on Thursday, November 5 at the Embassy Suites in Charleston.

Dr. Kenneth J. Doka, Ph.D., professor of gerontology at the College of New Rochelle, N.Y., will be the keynote speaker. Dr. Doka is associate editor of *"Omega"* and editor of *"Journeys,"* the Hospice Foundation of America's newsletter. In addition to his lecture at the meeting, Dr. Doka will also be conducting a free community forum on November 4 at 7:30 p.m. at the Cultural Center Theater.

Other presenters at the annual meeting will be Linda Cooper, R.N.-C.S., M.S.N., L.P.C., director of CAMC's Family Resource Center, and Sue Warren, M.D., F.A.C.P., medical director of Kanawha Hospice Care who is a clinical professor of internal medicine in the WVU School of Medicine.

To register or obtain more conference information, phone Amy Perrock at (304) 768-8523 or (800) 560-8523.

Healthy People Consortium scheduled

Assistant Secretary for Health and Surgeon General David Satcher will address representatives of the nation's public health community when they gather for the Healthy People Consortium meeting on November 12-13 in Washington, D.C., which will focus on Healthy People 2010 development.

The Healthy People 2010 assembly will take place just prior to the American Public Health Association's annual meeting, which is also being held in D.C. Satcher will speak at the Consortium's noon luncheon on Friday, November 13.

Consortium and non-consortium members are welcome at the meeting and registration must be made by November 1. For more details, phone Miryam Granthon at (202) 690-6245.

Ophthalmologists plan spring meeting

The West Virginia Academy of Ophthalmology's 52nd Annual National Spring Meeting is scheduled for April 22-25 at The Greenbrier in White Sulphur Springs.

Featured speakers include Philip Sheldon, M.D., Bruce Shields, M.D., Richard Lindstrom, M.D., and Walter Stark, M.D. Topics to be discussed include medical/legal issues, malpractice, managed care, glaucoma, cataracts and refractive surgery.

This event designated by the WV Academy of Ophthalmology for 15 credit hours in Category 1 of the AMA's Physician's Recognition Award.

For more details, contact the WV Academy of Ophthalmology, P.O. Box 5008, Chas., WV 25361; (304) 343-5842 or fax (304) 344-3130.

Foundation monitoring dialysis outcomes

In an effort to encourage patients to monitor their own treatment and to enable professionals to implement the National Kidney Foundation Dialysis Outcomes Quality Initiative guidelines, the foundation has developed a set of materials for both patients and health care professionals.

To obtain free single copies, call 1-800-622-9010.

Medical Assurance planning to hold 5K run annually

According to Kathi Burton of Medical Assurance of West Virginia, response to her company's Fun Run-Walk on Saturday, August 29 at 7 a.m. at this year's WVSMA Annual Meeting was so favorable that the event will be held an annual basis at the conference.

"The course which was set up at The Greenbrier ended up being a 5K which was longer than we planned, but everyone seemed very pleased with it," Kathi said. "Next year we hope to start the race later so we can have more participants."

The winners of this year's 5K race are as follows:

1st place - Dr. John Holloway of Wheeling

2nd place - Doug Wallace of SmithKline Beecham Pharmaceuticals

3rd place - Kathi Burton of Medical Assurance

4th place - Chuck Ellzey of Medical Assurance

ACC to meet in Williamsburg, Snowshoe

The American College of Cardiology has scheduled its *26th Annual Williamsburg Conference on Heart Disease* in Williamsburg, Va., from December 6-9, and its *18th Cardiovascular Conference at Snowshoe* in Showshoe, W.Va., from February 1-3.

A total of 18.5 CME credits for the AMA's Category 1 are being offered for the Williamburg conference at Williamsburg Lodge, and a total of 14.5 Category 1 credits are available for the Snowshoe meeting, which will be held in the Mountain Lodge Conference Center.

For more information, contact the Registration Secretary, Extramural Programs Dept., American College of Cardiology, 9111 Old Georgetown Rd., Bethesda, Md., 20814-1699; 1-800-253-4636, ext. 695; (outside the U.S. and Canada call (301) 897-9745.)

Medic Alert Adds Extra Emergency Hotline

Medic Alert is offering a new toll-free 800 number (1-800-625-3780) for its 24-hour Emergency Response Center for first responders.

This number supplements the call-collect (area code 209) number engraved on the emblems of the three million members in the U.S. and Canada, and enables responders to call directly.

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Charles D. Crigger, M.D.
D. Richard Lough, M.D.

AUDIOLOGISTS
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Susan D. Maynard, M.S., CCC-A
Janet D. Lauerman, M.A., CCC-A
Brenda D. George, M.S., CCC-A
Melissa A. White, M.S., CCC-A

CME & Special Events

Camcare Health Education & Research Institute

"Follow-Up Treatment of Common Cancers"
Oct. 26, 5:45 p.m., Steven Jubelirer, M.D., Cafe Acropolis, Summersville

"Fifth Annual Childbirth Educator's Day
Oct. 27-28, Coonskin Park Clubhouse, Charleston

"Prevention of Medication Errors"
Oct. 28, 5:45 p.m., Jeff Hess, Pharm.D., Tamarack, Beckley

Nov. 10, 5:45 p.m., 8 a.m., Sycamore Country Club, Ripley

Dec. 8, 6 p.m., Plateau Medical Center, Oak Hill

"Local Oncology Update"
Nov. 1, 5:45 p.m., James Frame, M.D., Logan Country Club, Chapmanville

Pediatric Surgical Emergencies"
Nov. 10, 6 p.m., Eduardo Suson, M.D., Plateau Medical Center, Oak Hill

"Research Day"
Nov. 11, 5 p.m. - 9 p.m., Robert C. Byrd HSC of WVU, Charleston Division

"Common Presentations of Acute Leukemia"
Nov. 17, 6:30 p.m., Richard Williams, M.D., Roane General Hospital, Spencer

"Topics in Anti-Coagulation Therapy"
Nov. 17, 5:30 p.m., David Anderson, M.D., Davis Memorial Hospital, Elkins

"Clinical Trials Management: The Typical and the Unusual Strategies for Success for the PI and Research Coordinator"
Nov. 18, 9 a.m. - 4:30 p.m., Robert C. Byrd HSC of WVU, Charleston Division

"Issues in Medical Ethics" (two 2-hour sessions)
Oct. 27 & Nov. 3 (5 p.m. - 7 p.m.), CamCare Health Education & Research Institute, Charleston

Huntington Community Medical Foundation

"Interventional Radiology"
Oct. 27, 7 p.m., Paul Capito, M.D., Paul B. Hall Regional Medical Center, Paintsville, Ky.

"AIDS in the 90s: The Changing Look"
Nov. 10, 6 p.m., Thomas Rushton, M.D., Highlands Reg. Medical Center, Prestonsburg, Ky.

"Trauma Conference"
Logan General Hospital, 7:45 a.m. - 1 p.m., Logan
"Initial Assess. of the Adult Emer. Patient" - Michael Mills, D.O.
"Pediatric Trauma Patients" - H. David Hinchman, D.O.
"Facial Trauma & Wound Reconstructive" - William Cocke, D.O.
"Cerebral Aneurysms" - Joby Joseph, M.D.
"Cervical & Spinal Trauma" - Edward Stewart, M.D.

Marshall University School of Medicine

"Principles & Importance of Wellness"
Oct. 25, 2 p.m., Deepak Chopra, M.D., C.A., Huntington Civic Center, Huntington

"Treatment of Onchomycosis in the Primary Care Setting"
Nov. 12, 6 p.m., Dennis E. Babel, Ph.D., Gateway H. Inn

"Essential Participation of Growth Hormone and IGF1 in Mammary Development,"
Nov. 16, 6:30 p.m., David L. Kleinberg, M.D. TriState EndoOct., TBA

"Adult Growth Hormone Deficiency - A New Syndrome"
Nov. 17, 8 a.m., David L. Kleinberg, M.D., St. Mary's Hosp.

Robert C. Byrd HSC - Morgantown

"Impotence"
Oct. 26, 4 p.m., H. Carlton Palmer, M.D., Greenbrier Clinic, White Sulphur Springs

"WV Rural Health Conference"
Oct. 28 - 30, Charleston House - Holiday Inn

"Schedule for Clinical Assessment in Neuropsychiatry"
Oct. 29 - Nov. 1, Chestnut Ridge Hospital, Morgantown

"Current Trends in PET Imaging"
Nov. 6, Robert C. Byrd HSC, Morgantown

"Surgery Update 1998"
Nov. 6 - 7, Robert C. Byrd HSC of WVU, Morgantown

"19th Annual Orthopedic Reunion Day"
Nov. 6 - 7, Erickson Alumni Center, Morgantown

"Fourth Annual Cost-Effective Evaluation and Management of Lower Back Pain"
Nov. 20, Robert C. Byrd HSC of WVU, Morgantown

West Virginia State Medical Association

WVSMA's Mid-Winter Clinical Conference"
Jan. 21-24, Embassy Suites, Charleston

Southern Vacation

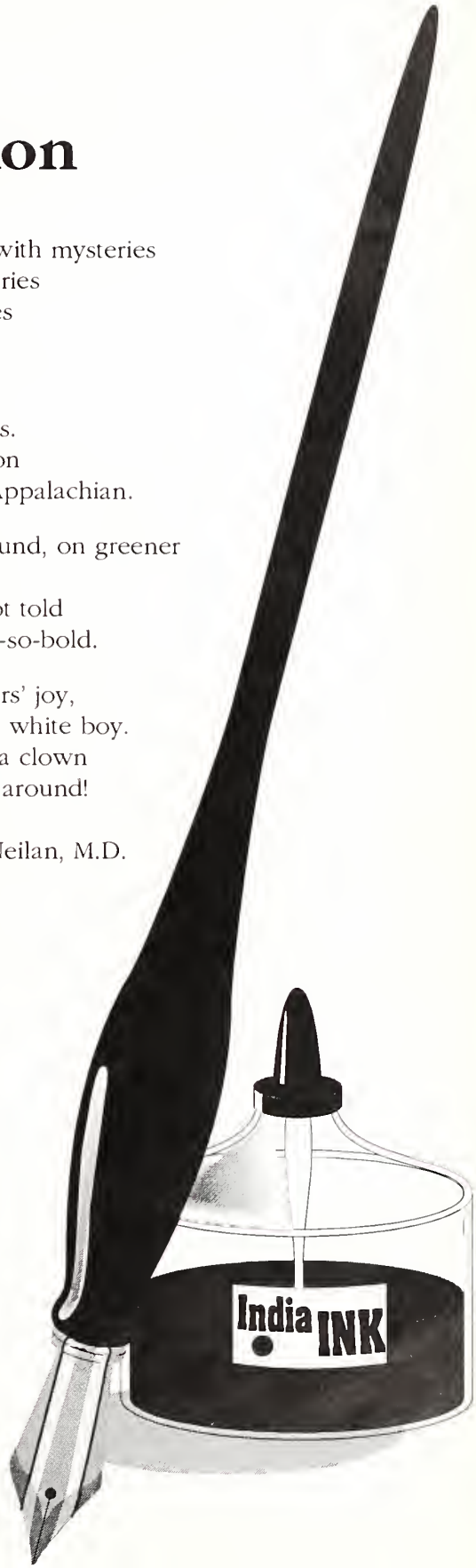
Traveling under golden light, blue skies, and white clouds with mysteries
In the flat lands of cornstalks, cows, kudzu, and old cemetaries
Houses and little groves of trees seemed to float in lazy lines
Like flotsam wafting on an ocean smell of pines.

It's possible there to build roads straight up their hills
Protected by pine needles on salvaged red clay without frills.
My time spent in plain towns in Southern states of our nation
I recalled all the way until the roads wound back into the Appalachian.

Compelling contrast between men here and men there, I found, on greener higher mountains, the roads snake onto higher ground.
While there's a pulse in Appalachia sons, love words are not told
Upfront but rather are concealed in mountain traditions not-so-bold.

For most, perhaps the charms of Southern women is travelers' joy,
But, I have loved the sturdy sunburned male that is the real white boy.
And find, I'm home in West Virginia wearing my heart like a clown
Among rednecks "pretending" those good ole boys are still around!

Lee L. Neilan, M.D.



Bureau for Public Health News

This page of material is submitted and paid for by the Bureau for Public Health.

Laboratory personnel licensure revised

The WV Clinical Laboratory Technician and Technologist Licensure and Certification Rule (64CSR57), which became effective in August of last year, has been revised. The new rule became effective July 1, 1998, and makes provision to license clinical laboratory personnel into four categories.

Individuals performing laboratory tests in West Virginia are qualified into one of these categories:

CLP-MT: Clinical Laboratory Practitioner - Laboratory Technologist

CLP-MLT: Clinical Laboratory Practitioner - Laboratory Technician

CLP-CT: Clinical Laboratory Practitioner - Cytotechnologist

CLP-POCT: Clinical Laboratory Practitioner - Point of Care Technician

Everyone performing clinical laboratory testing must be licensed unless exempted from the rule. Exemption include:

- Persons performing only waived tests under CLIA;
- Persons performing only provider-performed microscopy procedures under CLIA;
- Respiratory care providers performing moderate complexity testing within the scope of his/her license; and
- Persons performing lab tests only for themselves or members of their families, and physicians performing laboratory testing only on their own patients.

Persons applying for renewal of their license for 1999 will be required to submit proof of their participation in continuing education activities during the past year. For renewal, the applicant must have completed at least 10 contact hours (1 Continuing Education Unit) of educational activities commensurate with the level of complexity of the testing performed. Acceptable continuing educational activities include lectures, seminars, workshops, formal classes, in-service programs and correspondence courses.

Information about the new rule for lab personnel licensure and continuing education requirements was mailed to all laboratories in July. More information can be obtained by contacting Eloise Boggs, WV Clinical Personnel Licensure, Office of Laboratory Services, 167 Eleventh Avenue, South Charleston, WV 25303; (304) 558-3530 or fax (304) 558-2006.

Law expands who may administer meds in residential facilities

Unlicensed personnel under the supervision of an R.N. and an attending physician may administer specific medications to residents within designated health facilities as a result of legislation passed during the 1997 legislative session.

The emergency rule allowing the implementation of this law became effective in July.

The types of facilities in which the law allows for medication administration by unlicensed personnel are:

- Intermediate care facilities for the mentally retarded certified by the Department of Health and Human Resources (DHHR),
- Personal care homes, residential board and care homes;
- Private residences in which health care services are provided under the supervision of a registered nurse; and
- Adult family care homes licensed by or approved by the Department.

Initiative underway to reduce use of restraints in nursing homes

One area of care that HCFA has focused on in nursing homes is the reduction or removal of physical restraints. According to statistics compiled by HCFA, West Virginia has a restraint usage rate of 19.6% (2,128 of its 10,882 residents). This places West Virginia eighth in the nation for restraint usage.

As a result, the West Virginia Nursing Home Advisory Council and Office of Health Facility Licensure and Certification (OHFLAC) have begun steps toward the development of a restraint reduction program in West Virginia. Dr. R. Urbanowski at West Virginia University is assisting the initiative by conducting a survey of nursing homes in order to establish baseline data.

New communications coordinator named

The Bureau for Public Health has hired Mark Ferrell, a freelance journalist who has covered the West Virginia Legislature for West Virginia Public Television, as the new communications coordinator to replace Cathy Lee.

In his role as communications coordinator, Ferrell will be the media contact for the Bureau, and will also provide media and communications-related assistance to members of the staff.

To contact Ferrell, phone 558-0029.

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Robert C. Byrd Health Sciences Center of West Virginia University News

Brick appointed chair of Dept. of Neurology

Brick

Dr. John Brick has been named chair of the Dept. of Neurology.

Dr. Brick has served as WVUH's vice president of Medical Staff Affairs and as associate dean for hospital affairs in the School of Medicine for the last seven years. He will assume the post held by Dr. Lud Gutmann who has been a faculty member for 33 years. Dr. Gutmann will continue as a senior faculty member in the department.

"Lud Gutmann has been a wonderful friend for my entire professional career. It is a great honor for me to follow him as chair of neurology," says Dr. Brick. "Any of us would be happy to accomplish half as much in their career as Lud has. He is one of the handful of faculty members in this medical school who have over the years set the standard for service to the university and the people of West Virginia."

Neal chairing Children's Miracle Network board

Neal

Dr. William A. Neal, a pediatric cardiologist at WVU, is chairing the Children's Miracle Network's board of trustees.

CMN represents 170 children's hospitals in North America, which provide health care for 12 million children annually.

Groundbreaking takes place for Family House

Kelly Martin, 23, a leukemia patient from Buckhannon, operates a backhoe with Ed Kughn to break ground on the Family House, WVU Hospitals' $3.6 million project that will provide housing for long-term patients and their families. In the background are *(from left)* Bruce McClymonds, WVUH president, and CEO; Robert D'Alessandri, M.D., dean of medicine; and Scott Rotruck, vp and head of public relations for Anker Energy. During her cancer treatment, Kelly and her family spent several months in Morgantown, both in the hospital, and in an apartment building where the hospital rents space for long-term patients and their families.

Forensic psychiatrist joins WVU faculty

Justice

Dr. John Justice, a forensic psychiatrist, has joined the department of Behavioral Medicine and Psychiatry at WVU.

Forensic psychiatry is the study of the relationship between mental health and law. Dr. Justice will provide assessment of patients, expert testimony, and other services.

Ramsey accepts state director's position

Ramsey

Dr. William Ramsey has accepted the position of medical director of the WV Office of Emergency Medical Services.

Although he will remain at WVU, Dr. Ramsey has resigned his post as residency director of WVU's Dept. of Medicine. Dr. Rosanna Sikora will serve as interim director.

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Marshall University School of Medicine News

MU faculty write book to prepare students for first patients

Marshall faculty members have collaborated to create the first textbook designed to guide medical students through their earliest encounters with patients.

Published by McGraw-Hill, *"Becoming a Clinician: A Primer for Students"* is edited by Dr. Shirley M. Neitch and Dr. Maurice A. Mufson of Marshall's Department of Medicine.

"The idea of working with patients in the first year can disconcert the most aggressive medical student," Drs. Neitch and Mufson said in the book's preface. "We experienced the same feelings when we were medical students. We wrote this book as a 'handbook' for this transition."

Twenty other MU faculty members wrote chapters for the book, which John J. Dolan of McGraw-Hill called a "good read for anyone interested in becoming a doctor."

"This book provides the first tools for the beginning clinician," Dolan said in an Internet review. "Though the book is a useful tool for medical students seeing patients for the first time, anyone interested in the patient/doctor relationship will find the book interesting."

"Becoming a Clinician" is organized into three sections to help students learn to work with patients, understand their medical complaints, and evaluate their problems. Topics range from prenatal exams to chest pain, AIDS, and the handling of suspected domestic violence.

In addition to Neitch and Mufson, the following Marshall faculty members have chapters in the book: Dr. Bruce Chertow, Dr. Sachin Dave, Dr. Renee Domanico, Dr. Henry Driscoll, Dr. Lynne Goebel, Dr. Patricia Kelly, Dr. John Leidy Jr., Dr. Sarah McCarty, Diane Mufson, Dr. Nancy Munn, Dr. Robert Nerhood, Dr. Gretchen Oley, Dr. Thomas Rushton, Dr. Michael Skeens, Dr. Marc Subik, Dr. Marie Veitia, Dr. Ralph Webb, Dr. Paulette Wehner, Dr. Jayson Yap, and Dr. Kevin Yingling.

Dr. David Carr of Ohio University also contributed to the book.

Conference on liver disease among events for Alumni Weekend

The new Marshall University Medical Center will be the setting for several events during this year's Alumni Weekend, October 16-17.

This year's activities will kick off with a daylong conference on liver disease in the Harless Auditorium in the medical center. Presentations will include:

"Molecular analysis of Hepatitis C virus: Problems and progress," Suzanne U. Emerson, Ph.D., of the National Institute of Allergy and Infectious Diseases;

"Pregnancy specific hepatic disease: HELLP syndrome and acute fatty liver," Sabrina D. Craigo, M.D., Tufts University School of Medicine;

"Newborn jaundice: Evaluation and risk of bilirubin induced neurologic dysfunction (BIND)," Vinod K. Bhutani, M.D.;

"Evaluation and management of biliary strictures," W. Scott Melvin, M.D., Ohio State University;

"New Advances in Liver Disease," Robert Kirkpatrick, M.D., Ohio State University Hospitals; and

"Clinical pathologic correlation," Mark A. Subik, M.D., and Linda G. Brown, M.D., Marshall University.

On Oct. 17, Walter J. Carter will speak at 10:30 a.m. at the Medical Center on the Norval Carter Medical Society, named in memory of his father. At 11:15 a.m., Dr. Larry Schwab, clinical professor of ophthalmology at West Virginia University, will present the Albert C. Esposito, M.D., Memorial Lecture, *"Out of Sight."* Dr. Schwab, who has been associated since 1972 with the International Eye Foundation, will discuss preventable blindness and sight restoration in the developing world as an international public health problem.

Other events during the weekend will be an alumni/faculty mixer at the Radisson Hotel in Huntington at 8 p.m. on Oct. 16, and tours of the new medical center will be offered Oct. 17 from 9 a.m. to 10 a.m. and from noon to 1 p.m.

For registration information, contact the Office of Continuing Medical Education, 691-1770.

Student, alumnus earn national awards

Tanya Warwick, MS-III, was awarded second place in the medical student Drug Information Writing Competition sponsored by the United States Pharmacopeial Convention. Her winning patient information package focused on Haldol.

Charles Clements, M.D., PGY-3, is one of 20 recipients nationwide of a Mead Johnson Award for Graduate Education in Family Practice.

The awards are given by the American Academy of Family Physicians on the basis of scholastic achievement, leadership qualities, community involvement and exemplary patient care.

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West Virginia School of Osteopathic Medicine News

Second-year student named to national post

Neal

Wendy Neal, a second-year med student from Bluefield, has been appointed chairperson of the National Capitol Campaign for the Student Osteopathic Medical Association.

Neal is currently the local chapter president of SOMA, as well as the secretary of the Delta Omega Club, treasurer of the Addiction Medicine Club, a member of the Osteopathic Family Physicians, and an inductee of the Sigma Sigma Phi Honorary Fraternity. She graduated magna cum laude from Bluefield College in Bluefield, Va., with a bachelor of science degree in biology.

Neal's parents are David and Judy Neal of Bluefield.

Sixty-five freshmen report for fall class

Sixty-five students began first-year studies at WVSOM on August 10. A total of 1,630 applicants competed for a spot in this fall's freshman class.

The 65 members of the Class of 2002 will study basic sciences on the WVSOM campus for two years before spending the final two years of their medical education on clinical rotations at various hospitals, clinics and private practices.

Forty-five members of the Class of 2002 are from West Virginia. The other 20 students are from the South Appalachian region. More than half of the class, 54%, are female (35 out of 65).

Influenza vaccine study underway

Jackson

How can osteopathic medicine make the influenza vaccine more effective? That's the question several professors are investigating in a new study at the WVSOM to see if osteopathic manipulative treatment (OMT) can heighten the body's immune response to the influenza vaccine, thus increasing the vaccine's effectiveness.

"We want to examine the effects of OMT on an individual's ability to produce protective antibodies after receiving a vaccine," explained Kelly Jackson, Ph.D., an associate professor of microbiology at WVSOM who is the principal investigator for the study.

"A vaccine is a safe form of a particular virus or bacterium that, when introduced into the body, triggers our own natural antibody defenses. The bigger the response, the better. So our study examines ways to help trigger a heightened response in vaccinated people," says Dr. Jackson.

D.O.s have long felt that OMT can enhance the body's defenses against infectious diseases. Last year, WVSOM professors conducted a similar study which examined the effects of manipulation on people who were given the hepatitis B vaccine.

"That study showed a trend toward higher antibody responses in those persons who received OMT," notes Dr. Jackson. "We now want to expand the study with the influenza vaccine and see what kind of results we get."

WVSOM ranks high in primary care survey

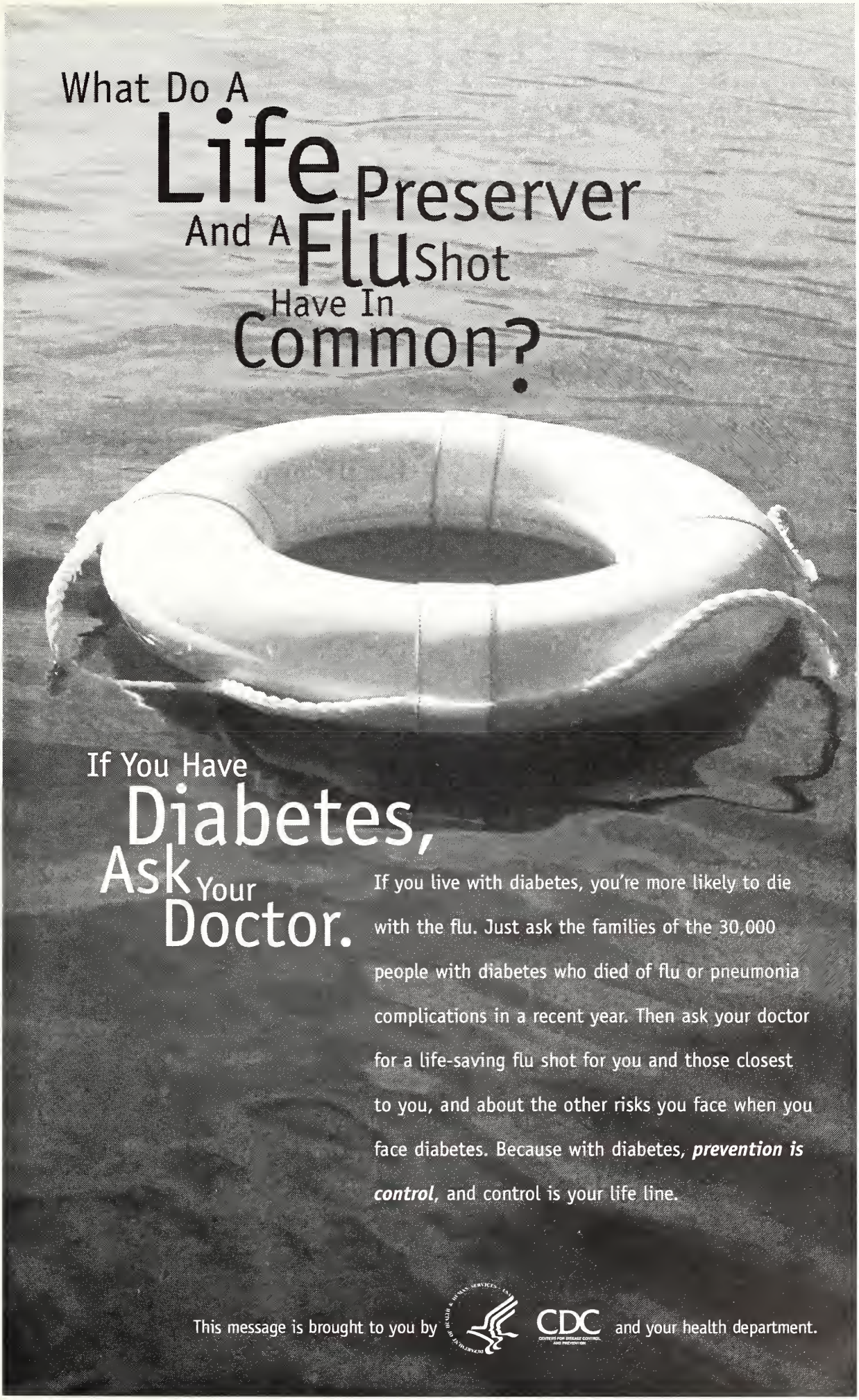
The West Virginia School of Osteopathic Medicine is among the nation's best in producing family doctors and primary care physicians, according to a study in the April issue of the magazine *New Physician*.

The American Medical Student Association, an independent organization of more than 30,000 medical students, reviewed the most recent data on the number of grads in primary care residencies from 125 allopathic (M.D.) and 18 osteopathic (D.O.) medical schools.

WVSOM was rated the No. 2 school in the survey, with 70 percent of its 1996 graduating class in family practice residencies. In the broader spectrum of primary care — which includes family medicine, internal medicine, obstetrics and gynecology, and pediatrics — WVSOM ranked No. 5 in the nation, with 77 percent of its graduates pursuing residencies in these disciplines. Osteopathic medical schools claim the top 12 spots in the rankings.

"At WVSOM, providing primary care physicians to our state and the Appalachian region is the mission of our school," said Olen E. Jones, Jr., Ph.D., president of WVSOM. "So we are very pleased with this recognition from *New Physician* magazine because it shows that our graduates are meeting the demand for family doctors and filling a real need in society.

"Many areas of our state still suffer from a lack of adequate medical care. In the underserved regions of West Virginia, it's not unusual for a family to drive great distances to reach the nearest health care facility," Dr. Jones said. "Our school was created specifically to address those shortages," he added.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Unite for progress

During my Inaugural Address to the Alliance House of Delegates, I outlined my theme for this year - - *Unite for Progress.* To achieve unity and progress, I will working with the Alliance members throughout the state on the areas of membership, health projects, the AMA Foundation, and legislation.

Membership is the primary concern for many organizations and our organization is no exception. During the past 20 years, Alliance membership has dropped by half. I have issued a challenge to increase our membership by 20 percent this year. Membership is our most vital resource. Without members we can not accomplish the many projects that benefit the health of West Virginians everyday. Even if your spouse cannot be an active member of the Alliance, they can unite with us and support our projects through their dues.

In the area of health projects, we will unite with Southern Medical Association Auxiliary to promote Breast Cancer Awareness. We have ordered self-examination models that will be available to all of our county Alliances, and the Alliance will be one of the sponsors of the statewide *Walk for the Cure* in October. We will also continue our efforts with *SAVE - Stop America's Violence Everywhere.* This program has brought hope to millions across this country with the support of anti-domestic violence programs and conflict resolution. In addition, another health project for this year will be the AMA's organ donor program entitled *Live and Then Give.*

The third area of activity will be the newly named AMA Foundation. During our convention, we raised more than a $1,000 for the Foundation, thanks to the efforts of Michelle Latos and the Ohio County gang. Last year, the Alliance raised more than $18,000 for the benefit of the medical schools in West Virginia. Together we can unite to raise even more this year.

Legislation will be our fourth topic of concern. The Alliance stands ready to unite with the WVSMA to further its' legislative agenda. Our phone banks are available to spread the word at a moment's notice. We will help bring issues to our legislators whenever called upon. Your issues are our issues.

The Alliance is very grateful for all of the support of the WVSMA throughout the years. We will help in anyway we can to advance the goals of the WVSMA. We invite you to help us by making sure your spouse is a member of the Alliance.

Jerry Crites
WVSMA Alliance President

New Members

We are pleased to welcome the following new members to the WVSMA:

Physicians

Joseph L. Boggs, MD
Parkersburg, WV

D. Richard Lough, MD
Charleston, WV

C. Pamela Parmar, MD
Wheeling, WV

Nalini A. Reddy, MD
Morgantown, WV

Michael Panger, MD
Charleston, WV

Manimekalai Veeraswamy, MD
Huntington, WV

George W. Shehl, MD
Clarksburg,WV

David H. Church, MD
Clarksburg, WV

Sathyanarayan Reddy, MD
Clarksburg, WV

Nick A. Ghaphery, DO
Wheeling, WV

Jasmine Trouten, MD
Wheeling, WV

Pam Webber, MD
Wheeling WV

Robert L. Vawter, MD
Wheeling, WV

Joseph P. Cincinnati, MD
Morgantown, WV

Ismail Salahi, DO
Charleston, WV

Lloyd A. Kurth, MD
Morgantown, WV

Nick L. Zervos, MD
Morgantown, WV

Cherry B. Lobaton, MD
Martinsburg, WV

Kevin T. McLaughlin, DO
Berkeley Springs, WV

Blake D. Alexander, MD
Morgantown, WV

Murray D. Batt, MD
Clarksburg, WV

Roberto Reyna, MD
Martinsburg, WV

Inder K. Khurana, MD
Keyser, WV

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(This list includes contributions made from 7/11/98 to 9/17/98.)

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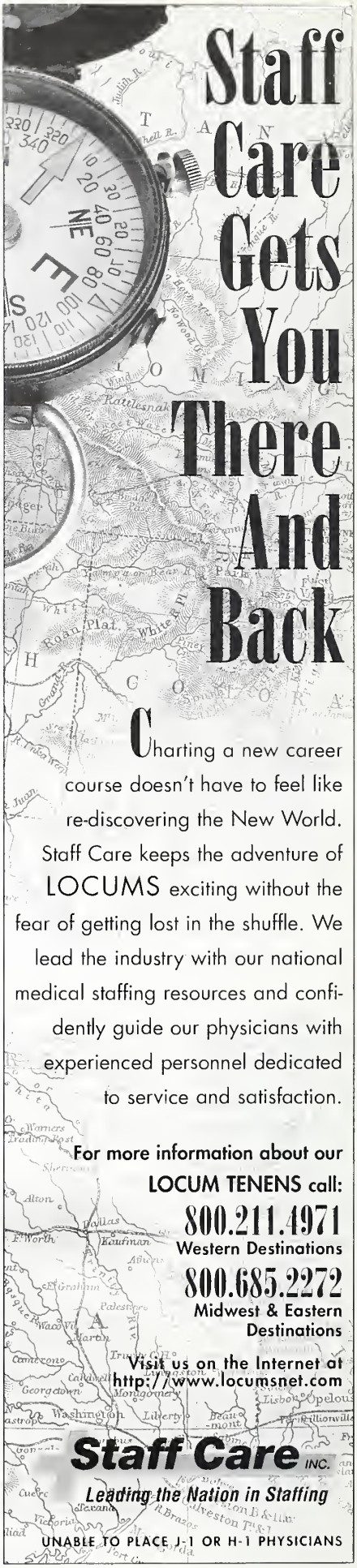
I certify that the statements made by me above are correct and complete.

Signed Nancy L. Hill
Managing Editor



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Seminars

Cardiology Conference at Snowshoe (with the American College of Cardiology)
February 2-4, 1999
Mountain Lodge Conference Center
Snowshoe, WV
William Carter, MD
Program Chairman

Type II Diabetes: A Primary Care Approach
Wednesday, January 27, 1999
12:30 p.m. – 5:00 p.m.
(Afterwards a limited number of tickets will be available for the WVU vs. Marshall University basketball game, registration is required.)
Charleston Civic Center
Charleston, WV
Steven Artz, MD
Program Chairman

OB/GYN Update: A Pre-conference for the Family Physician
Thursday, April 22, 1999
5:00 p.m. – 9:30 p.m.
Charleston House Holiday Inn
Charleston, WV
E. Reed Heywood, MD
Program Chairman

26th Annual Newborn Day: Hematology Disorders of the Newborn
Friday, April 23, 1999, 7:30 a.m.
Tamarack, Beckley, WV
Stefan Maxwell, MD
Program Chairman

Issues in Medical Ethics
Wednesday, June 9, 1999
8:00 a.m. – 5:00 p.m.
Tamarack, Beckley, WV
Robert T. Hall, PhD
Program Chairman

On-Site Continuing Education Outreach Programs

Basic Pediatric Emergencies
December 7, 1998, 10:00 a.m.
Montgomery General Hospital
Montgomery, WV
Pediatric Transport Team
Women & Children's Hospital

Prevention of Medication Errors
December 8, 1998, 6:00 p.m.
Plateau Medical Center/Fayette County Medical Society
Plateau Medical Center
Oak Hill, WV
Jeff Hess, PharmD

Basic Pediatric Emergency
December 21, 1998, 10:00 a.m.
Montgomery General Hospital
Montgomery, WV
Pediatric Transport Team
Women & Children's Hospital

Aftermath of the MIDCAB Procedure
January 6, 1999, 12:30 p.m.
Montgomery General Hospital
Montgomery, WV
Ozuru O. Okuha, MD

New Guidelines for Head & Spine Injury
January 8, 1999, 12:00 noon
Logan General Hospital, Logan, WV
Sherry Apple, MD

Update in the Treatment of Asthma
January 12, 1999, 12:00 noon
Plateau Medical Center
Oak Hill, WV
B. Nassiri, MD

Forensic Evidence in the Emergency Department
January 18, 1999, 5:45 p.m.
Jackson County Regional Outreach
Sycamore Country Club, Ripley, WV
Michael King

Update on Alzheimer's Disease
January 19, 1999, 6:30 p.m.
Roane General Hospital
Spencer, WV
James Griffith, MD

Medical Treatment of Pneumonia
January 20, 1999, 6:00 p.m.
Man ARH, Man, WV
Alfred Pfister, MD

Chemical Hazards in the Kanawha Valley
February 3, 1999, 12:30 p.m.
Montgomery General Hospital
Montgomery, WV
Bipin Avashia, MD

Management and Work-Up of Anemia
February 17, 1999, 6:00 p.m.
Man ARH, Man, WV
Steven Jubelirer, MD

Common Presentations of Acute Leukemia
March 3, 1999, 12:30 p.m.
Montgomery General Hospital
Montgomery, WV
Richard Williams, MD

Renal Transplantation Update
March 12, 1998, 12:00 noon
Logan General Hospital, Logan, WV
Lawrence Wyner, MD

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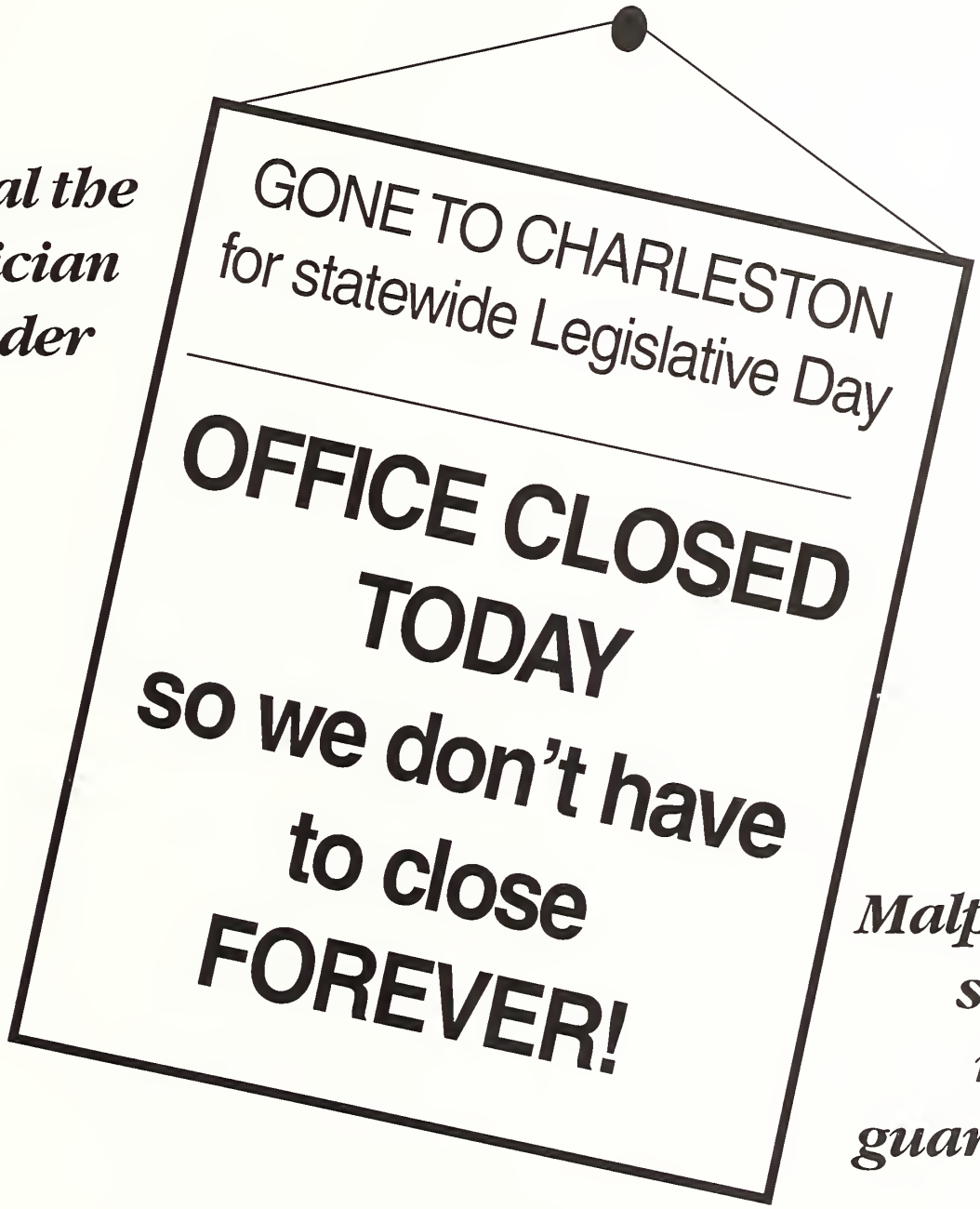

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A white-tail deer in the snow in Tucker County.

Photo courtesy of Stephen J. Shaluta Jr., West Virginia Department of Commerce.

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Manuscript Guidelines

All articles for the *West Virginia Medical Journal* must be submitted on an IBM compatible disc. Wordperfect 5x, Wordperfect 6.0/6.1, Microsoft Word for DOS, and other languages are acceptable. If the manuscript contains tables, the main body of the manuscript and references should be saved as one item, i.e., *article*, and then each table should also be saved as a separate item, i.e., *Table 1, Table 2.*

All scientific manuscripts should be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."* Papers will not be considered for publication if they have already been published or are described in a manuscript submitted or accepted for publication elsewhere. All persons designated as authors should have participated enough in the work to take public responsibility for the concept.

Manuscripts should be accompanied by one extra copy, be double-spaced, have each page numbered and should include a title page, an abstract of no more than 150 words, and references numbered consecutively. No more than 10 references will be published and then a statement will appear that the author should be contacted for the

Tables, figures and photos should be numbered, and indicated with parentheses whenever they are mentioned in the text, i.e. (Table 1), (Figure 1). Legends should be included for all figures and photographs.

Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author at a cost of $13 for each photo. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be created in black and white.

All scientific material is reviewed by the editor and three members of the Publication Committee. Depending on their content, other types of articles are usually only reviewed by the editor and should still be mailed to the same address. All articles should be addressed to: Stephen D. Ward, M.D., Editor, *West Virginia Medical Journal*, Charleston, WV 25364.

If you have questions or need more information, phone Nancy L. Hill, managing editor at (304) 925-0342.

President's Page

Let's bury the hatchet, but not the cannon

Different strategies, different priorities and different agendas.

At first glance, we see these major differences in the associations throughout West Virginia and across the country. The West Virginia State Medical Association, the West Virginia Hospital Association and the West Virginia Nurses Association are among the most evident organizations with these glaring differences. However, if we take a closer look, we see fundamental similarities within each of them.

We would see that we are all struggling to fight battles in the Legislature, we are all working day and night to recruit and retain members, and we are all trying to move forward with our organizational goals. But most importantly, we are all weaker alone than we are together.

The WVSMA leadership is making major strides to work with various associations throughout the state. The common thread is there . . . we just need to find it.

In October, both the Nurses' Association and the Hospital Association have met separately with the WVSMA to discuss the upcoming legislative session. The leaders from each organization were present and openly discussed agendas, strategies and priorities for the 1999 session.

The WVSMA has long been viewed as arrogant, overwhelmed, and too busy to be friendly with other associations and try to work together. The current medical climate is much too unpredictable to continue on this path.

Since taking office in August, I have had the opportunity to travel to many neighboring states for annual meetings, including Indiana, Kentucky, Pennsylvania, Virginia and Maryland. It is always a very wonderful experience, and also gratifying to learn that we all have very similar problems.

However, the majority of states I have visited have much better relations with other organizations, such as the hospital association, medical groups, physicians and hospital-based medical groups. On occasion, joint meetings were held with the medical society and the hospital association.

It is imperative that we stop the bickering amongst ourselves. It weakens our position in the Legislature and it is obvious to legislators when we are so busy arguing with each other that we don't fight for what physicians and patients really need.

What is the common thread?

What can we promote together?

Our goal should be finding the similarities in our organizations and promoting them. We need to realize the importance of the good of the many, not simply the good of the one.

Change will happen. It is already happening. We are talking with each other, trying to work together.

Let's bury the hatchet. Put our differences behind us and move on. Together our power will make a strong cannon to help our profession, but above all — to help our patients.

David W. Avery, M.D.

Addendum

On behalf of the Executive Committee and Council, I am pleased to announce that Nancie Albright will become Acting Executive Director of the WVSMA effective January 1, 1999, concurrent with the resignation of George Rider. We have the utmost confidence in Nancie's ability to run the association while the Search Committee continues the selection process for the new Executive Director.

We know that in times of change, anxiety levels rise and we wish to again state our support for the current medical association staff in all its endeavors.

Editorial

Assassins

In the aftermath of the shooting death of a New York abortionist, we were surprised to learn on National Public Radio that the total number of doctors supplying abortion services in the last several years has been diminishing. We were even more surprised to learn from NPR that the obvious reason for this falling out is that doctors are simply unwilling to face the risk of assassination in order to provide such needed and worthwhile services to all those women desperately clamoring for abortions.

The slain doctor was eulogized in heroic terms for his steadfast lifelong career in abortion in spite of the risks. The implication was quite clear: doctors who have stopped their abortion practices are a bunch of sniveling cowards for refusing to courageously carry on.

Now, we are not privy to statistics on the number of doctors currently providing abortion services nor are we aware of what those figures may have been in the past. We are aware, however, of the fact that the statistics on physicians who regard themselves as either pro-abortion or anti-abortion are not at all dissimiliar from the statistics of the general population. Those statistics find that the population on the whole is pretty evenly divided on the subject.

Not all doctors who favor abortion actually do abortions. That has always been quite clear, so that number of doctors is absolved from the charge of being cowardly. We also believe there may be other reasons for doctors discontinuing that portion of their practice dealing with abortion, if, in fact, that number has decreased.

Some may have been honestly converted to the pro-life way of thinking; some may simply have become bored at the routine and unchallenging drudgery of doing abortions and decided to take up something a little more stimulating; some, indeed, may have been affected by the lingering stigma attached to someone known as an "abortionist" and decided to rid themselves of what they regard as an opprobrious title. Perhaps there are a number who became unwilling to have their names and reputations associated with groups or organizations who found it agreeable to issue false statistics and lie about the number of late-term abortions actually being provided in this country.

Doctors and medical personnel in general have consistently earned praise and commendation for their frequently heroic performance on the battlefield in any war. Surgeons in the operating room attending to the needs of AIDS patients routinely expose themselves to risks far greater than anyone who provides abortions might experience from snipers and other assorted assassins. Over the centuries, doctors have routinely exposed themselves to the hazards of infection and pestilence without undue complaint. Doctors who have been motivated by violence to change their practices probably do so on the basis of exercising good sense rather than cowardice.

Making doctors who provide abortions into heroic characters isn't likely to increase the number of doctors doing abortions, nor is it likely to discourage those misguided assassins who apparently believe they are doing God's work in gunning down those whom they judge and condemn to execution.

Stephen D. Ward, M.D.
Editor

Guest Editorial

The case for political action committees

The following is an abbreviated version of an article written by Charles L. Garrett, Jr., M.D., president of the North Carolina Medical Society, which was published in the August issue of the North Carolina Medical Society Bulletin. It is reprinted with permission from the North Carolina Medical Society.

PACs were authorized by law in the 1970s as a reform. The purpose was to allow citizens of average means to band together, pool their small, after-tax, and voluntary contributions, and be able to compete with wealthy individual donors. It was also a recognition that America is a nation of interests which have a desire and constitutional right to participate in the campaign process. PACs were seen as a way to channel this involvement in a fully disclosed and appropriately limited manner.

More than two decades later, PACs are one of the few reforms that have worked exactly as intended, and then some. By promoting civic knowledge and involvement, PACs have stimulated millions of Americans to become active in the process. There have been no significant abuses associated with PACs in their 24-year existence — including the wide-scale abuses alleged in the 1996 campaign. PACs remain a reform with an unblemished record. They should be considered a model for reform — not something to be abolished or further limited.

PACs are comprised of individuals who come together for the purposes of helping to elect or defeat candidates and to pursue issues which are of mutual interest to the group. They are often sponsored by various organizations, such as associations, corporations, labor unions, and philosophical issue-oriented groups. These organizations and individuals engage in civic education and seek a stronger voice in the political process. All PACs depend on small, personal, and voluntary contributions from their members to fund contributions to candidates. Individual contributions to them are limited to $15,000 per-year, but average far less than that. They are prohibited from receiving any contributions or any direction from foreign entities or individuals.

PACs which meet certain thresholds under the law can contribute up to $5,000 per-election to a candidate, or $15,000 per-year to national political party committees. The vast majority of them rarely make maximum contributions. They are "hard" money operations, meaning that they are regulated and that their funds go directly to candidates. PACs themselves do not engage in "soft" money donations. How they decide which candidates to support also varies broadly, but most rely on a committee or board which is representative of the donors. Finally, most of them routinely conduct educational efforts to encourage participation in the election process.

Eliminating PACs will backfire. The unintended consequences of banning PACs include: forcing interests to operate in less accountable, less transparent, and less limited ways; discouraging the massive citizen participation which PACs have nurtured; concentrating influence and power in fewer groups and wealthy individuals; making campaign resources more scare, forcing candidates to spend more time raising money and/or affording voters less communication and dialogue; and decreasing the availability of funds for candidates without access to personal wealth.

Reducing PAC limits and imposing aggregrate PAC limits on candidates are equally unsupportable.

The current PAC limits set in 1974 have already been eroded by more than two-thirds by inflation. Setting PAC limits at the same level as individual limits may have some superficial appeal, but completely violates the whole PAC concept that Americans of average means ought to be able to pool their small contributions to compete with wealthy donors.

From the beginning, PACs have lived up to the mandate of their reformist beginnings. What's more, they alone can claim to have actually increased political participation in an area where it has been on the decline. Voters support the right of PACs to participate, in spite of two decades of negative rhetoric. Proposals to eliminate or further restrict PACs lack any public policy benefit, are at a minimum, constitutionally suspect, and, in fact, will be counter-productive to the stated goals of reform. No credible campaign finance expert or study supports anti-PAC legislation. PACs remain the cleanest, the most disclosed and regulated, and the most citizen-intensive part of the current system. As such, far from being curtailed, they should be seen as a model reform and encouraged.

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Special Correspondence

Editor's Note: The Public Employees Insurance Agency is facing a $54 million deficit and recently released a draft plan which, if fully implemented, would replace the current indemnity plan with a "Preferred Provider Benefit." Based on "efficiency and cost," in the second year of this proposed plan, some West Virginia physicians could be denied payment for serving PEIA patients. In reponse to this proposal, the West Virginia State Medical Association, the West Virginia Chapter of the Academy of Family Physicians and the West Virginia Society of Osteopathic Medicine, Inc. sent the following communication to the PEIA Finance Board.

MEMORANDUM

To: Members of the PEIA Finance Board

From: David Avery, MD
President of the West Virginia State Medical Association

Linda Savory, MD
President of the West Virginia Chapter of the
American Academy of Family Physicians

Howard A. Hunt, DO
President of the West Virginia Society of Osteopathic Medicine, Inc.

Re: Benefit Plan Changes

Date: Nov. 12, 1998

The West Virginia State Medical Association, the West Virginia Chapter of the Academy of Family Physicians, and the West Virginia Society of Osteopathic Medicine, Inc. submit the following preliminary comments in response to PEIA's draft plan released last Friday. During the coming weeks, it would be our hope that we can engage in more detailed discussions to better understand the ramifications of some of the proposed changes and possible alternate solutions.

We want to emphasize that we do realize that the choices before you are extremely difficult in the face of a potential $54 million deficit. Clearly, the program must remain solvent for it to survive — a goal we wholeheartedly support.

However, it is also true that in order for beneficiaries to avail themselves of needed services, care must be taken to preserve the delicate balance between cost efficiency and reasonableness. **We are certain no one wants to create a situation in which payments are so low as to discourage physician participation in the PEIA program. This harms beneficiaries just as certainly as increased patient deductibles and copayments**. It is easy to lose sight of this fact as one calculates just where the savings may come from.

With that in mind, we ask that the Board remember that West Virginia physicians have made sacrifices as recently as January of this year. In fact, physician reimbursements have been cut to 1994 payment levels. PEIA documents demonstrate that the RBRVS Conversion Factors for physicians were $43.28 in 1994, $44.76 in 1995, $45.66 in 1996, $45.66 in 1997 and since January of this year were cut to the 1994 payment level of $43.28.

In addition, the program has now placed the responsibility for pre-authorizations from the patient to the physician with a 30 percent penalty on payments when such pre-authorization is not obtained.

It is easy to assume that physicians can best bear the brunt of the program's financial woes. However, inflation and other increased costs affect physicians who must pay for equipment and supplies, office overhead, medical malpractice insurance, etc. Therefore, any freeze in payments constitutes an actual cut. Again, this is on top of a payment system that is at 1994 levels!

Although we strongly endorse the effort to control the provision of out-of- state care, we have serious concerns as to the design of the Preferred Provider Benefit plan in Fiscal year 2001. Essentially this construct eliminates the indemnity plan and therefore limits patient choice. Normally, health plans which restrict patient choice provide the "trade-off" of then reducing beneficiary copays and deductibles. In this case, PEIA would be both limiting choice and actually increasing out of pocket expenses. Additionally, we question the logic of your point of service plan which would continue to reimburse out- of-state non-network physicians, while denying the same benefit to in-state physicians. Ultimately, this will again exacerbate the migration of care to border states.

While a "credentialed network" sounds reasonable, unfortunately experience demonstrates that too often the "credentialing process" is a way to limit physicians who provide "too much" care to their patients. The draft plan suggests that "efficiency" and "cost" are the main considerations for credentialing, leaving one to then hope that somewhere in "other factors" quality might be a goal.

Our three organizations contend that a more successful strategy for the program lies in a defined contribution plan with cafeteria style benefits which would permit the beneficiary to choose from an array of options. Recreating the wheel is not a necessary evil in this case as such an approach is already being successfully utilized for federal employees.

Also, we would like to formally offer and recommend that you enlist the assistance of our members in advising the PEIA relative to one very important, yet overlooked issue. That is the potentially significant savings that could be realized by removing the disincentives to performing certain surgical procedures in physician's offices.

Finally, we are hearing that it is becoming more likely that a tobacco settlement is near. We urge the administration to utilize these potential funds for the health care needs of its citizens and specifically the PEIA program.

Special Article

Anesthesiology externship program making an impact in the lives of medical students

ROBERT E. JOHNSTONE, M.D.
Professor and Chair, Department of Anesthesiology, West Virginia University School of Medicine, Morgantown

GAIL A. PETTERS, M.D.
Former Assistant Professor and Director of Medical Student Education, Department of Anesthesiology, West Virginia University School of Medicine, Morgantown

West Virginia medical students, similar to students throughout the United States, are entering anesthesiology at a very low rate. In 1997, only 173 U.S. senior medical students selected first-year clinical anesthesiology positions through the National Residency Matching Program, and in 1996, just 126 students were matched into first-year clinical positions.

These numbers are far less than the generally-accepted 600 anesthesiologists needed per year to replace those from the 30,000 anesthesiologists who retire or transfer. West Virginia has approximately 150 full-time anesthesiologists, so six to eight new practitioners are needed in the state each year to maintain current levels.

The only anesthesiology residency program in the state is located at West Virginia University. Each year, three to eight residents finish training and approximately half remain in West Virginia to practice, many because they have family members in the state. The program cannot meet all the recruitment requests it receives for anesthesiologists from West Virginia hospitals and physician practice groups. Health care investigators report that the one-third of U.S. hospitals (primarily rural) which have no anesthesiologists on staff may never attract any, unless students from those rural communities enter the specialty. Those hospitals with adequate numbers of anesthesiologists may offer enhanced pain management, critical care, and perioperative services, as well as advanced surgical anesthetic techniques.

Why have U.S. and West Virginia medical students shown little interest in anesthesiology? Undoubtedly, many reasons exist, but one is that they probably know little about anesthesiology. Most students have minimal exposure to anesthesiology before selecting a residency. Only 36 percent of U.S. medical schools offer anesthesia rotations, and only 17 percent require them. Many rotations that do occur are during the fourth year, after students have entered the residency matching program, and thus these rotations do not influence their career. Rotating internships, as basic training for all specialties, no longer exist. Students must generally select a career choice during their third year of medical school.

Lack of early exposure to anesthesiology is unfortunate for both students and the health care community because more anesthesiologists are needed, and it is an exciting and challenging specialty. When students gain an understanding of anesthesia practices they often become enthusiastic about it, as well as obtain a better understanding of the wide range of physician practices. The practice of anesthesiology applies basic sciences, encounters the full range of medical problems and involves many procedures. Anesthesiology combines advanced technology and individual responsibility in a team environment.

Anesthesiologists often recall that their interest in the specialty arose from positive interactions with practicing anesthesiologists early in medical school. Since opportunities for practitioners and students to meet seemed to be dwindling, the WVU Anesthesiology Department designed a summer experience for first-year medical students. Now in its fourth year, this program is growing, and wins praise from all involved. Faculty anesthesiologists serving as mentors report great satisfaction, and students serving as externs describe interest in anesthesiology as a future career.

How does the program work? Medical students are sent a letter during their first year describing the program, which pays them a stipend of $200 per week, and lasts four to 10 weeks during the summer between their first and second years. Interested students are invited to apply, and those expressing the most enthusiam are selected. Externs learn anesthesia and operating room practices quickly, and after several weeks become very helpful. Patients respond to the compassionate manner most learners possess, and staff members like the intellectual stimulation an inexperienced, but curious and interested student offers. Externs prefer to have a textbook and some assigned reading. Most find working with several anesthesiologists, in a variety of settings, the best arrangement.

Externs describe the most valuable parts of their experience as hands-on learning, doing procedures, individual attention, integrating basic sciences with

clinical care, and interacting with patients. Externs uniformly enjoy the experience, perceive an advantage in starting the second year, and express interest in anesthesiology as a career. Some of today's externs will probably become tomorrow's accomplished anesthesiologists. The students, however, who select another career will still have a deep understanding of the anesthesia process, and can help patients prepare for surgery and anesthesia.

Faculty anesthesiologists report rediscovering the original fun of anesthesiology as a result of mentoring the students. The enthusiasm of students seems contagious and anesthesiologists learn themselves as they teach. Most anesthesiologists involved with the program feel that externships are a good way to attract bright West Virginia students into anesthesiology and to enhance the image of the specialty.

Seven students completed anesthesiology externships in 1996, eight in 1997, and eight in 1998. We asked these 23 students to fill out anonymous surveys. The results have led to minor modifications in the program, such as more flexibility in starting and ending dates. Several students reported an interest in experiencing anesthesia externships in their hometowns. We have contacted anesthesiologists in West Virginia, and found that many are interested in serving as mentors. Community externships have now been offered to students since last year.

During 1998, one student completed an anesthesia externship in Huntington. The student has family connections in the Huntington area, and currently plans to return there as an anesthesiologist or pain management specialist. Practitioners in Charleston, Huntington, Wheeling and Martinsburg have recently offered to sponsor externs so the program should continue to grow. Students from the first externship are now applying for residencies and at least two are planning to pursue anesthesiology.

WVU's anesthesia externship program will hopefully motivate more West Virginia students to entering anesthesiology and increase understanding about this specialty. Students at any of West Virginia's medical schools who are interested in this program may contact the WVU Department of Anesthesia at (304) 598-4122.

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A judgment of love . . . not money

A. H. MORAD, M.D.
Jackson Surgical Associates, Inc., Ripley

A few years ago, I made a trip to Shiraz in the southern part of Iran for a surgical conference. Shiraz is a very pretty city of approximately one million people, and its university was a sister university to the University of Pennsylvania at that time.

At the conference, I was pleased to see an old friend who had done his surgical training in Baltimore while I was an intern at the Baltimore City Hospital. He was now practicing in Shiraz and he invited me to have supper at his home with him and his wife.

After dinner, he asked me when I would be leaving the country and if I was busy the following morning. I said my plans for tomorrow were to go sightseeing. He told me that if I could postpone the sightseeing that I could attend one of the malpractice-type suits typical to Shiraz. I told him I was very interested and he told me he would pick me up at the hotel and take me to the courthouse where the suit would be heard. I was surprised when I asked him how many days the case would last and he said probably just one morning.

To prepare me for what would transpire in court in the next morning, he gave me the following details:

The doctor who was being sued had been trained in France as an obstetrician/gynecologist. He had performed a tubal ligation on a 28-year-old lady who had two children. The day after her surgery, he had flown to France to attend a conference.

After the doctor left town, this patient became very ill with vomiting. Her husband took her to the emergency room and she was admitted to the hospital. Unfortunately, the hospital did not diagnose her as having a perforation of the bowel and she developed peritonitis and died after several days.

The doctor who performed the surgery was not back in the hospital for two weeks after the lady died. The husband sued the doctor and, as it is the practice in Shiraz, the judge who reviewed the case asked two experts, both doctors, to give their opinions. My friend had been asked to be one of the experts and the other expert selected was an obstetrician/gynecologist who my friend did not know. My friend and the other expert were to appear before the judge and give their opinions.

The next morning, my friend and I went to the courthouse, where the proceedings took place in a large room with no audience except the two doctors, the husband of the deceased patient, their two children and myself. There judge entered the room alone and we stood until he gave us permission to sit. There was someone there to take notes.

The judge began by asking my friend "Did you review the case of Mrs. XXXX?" He stood and said "Yes sir, I did." The judge then asked my friend to give his medical opinion on the case. He stated very clearly that he thought that there was negligence involved because the doctor did operate on the patient, left town and the patient died. He further stated that if the doctor had been present, that he probably could have saved this patient's life. The judge thanked him and he sat down.

Next, the judge called the other surgeon and asked him the same question. The second surgeon also said that he had reviewed the case and thought that the doctor should not have left town, or if he was going to leave he should have made sure that the patient was all right before he left. He stated that there was definitely neglience involved in the case. The judge thanked him and the second expert sat down.

The judge then asked the surgeon who had performed the operation what he thought about the case. The doctor stood up and said, "Your Honor, I have to confess that I was negligent in this case. I did the wrong things. I shouldn't have left town. I feel guilty in this case and I'm very sorry." The judge waited a few minutes and then gave permission for the doctor to sit down. The judge told us he would be back with his ruling and he left the courtroom.

After 15 or 20 minutes, the judge returned and everyone stood as he entered. He stated that he had reviewed everything and had reached a verdict. He said that he found the doctor guilty of negligence and so being, he must take care of these two little girls financially until they were grown. If they go to college or not, he must do this. He would also be responsible for giving a dowry for the girls to be married and he must provide for them after marriage if needed. That was the end of the judgment and the doctor was given permission to speak.

The doctor stood and tears started flowing from his eyes as he said, "Your Honor has given me the privilege of being a Godfather for two children in addition to my own two children. I have to say that I will take these

children as my own and I'll do my best to raise them and make them happy. I will include them in my life and treat them as my own children and they will share in my inheritance. Furthermore, I would like to have permission from the father of these children to give me the honor of welcoming them into my home to care for them as my own children. Also, I will help the father build a nice house for these children. You have give me the honor of participating in the raising of two children, having another brother and extending my family."

The judge asked the children's father, "How do you accept these statements?" The father also had tears in his eyes and told the judge that he accepted his judgment. He added that he felt the doctor did not have intentions to do this to his wife and he fully forgave the doctor for his mistakes. The husband said he was sure that his wife would forgive him too, and he prayed God would forgive him also.

At this point, the husband hugged the doctor and held his hand while they both cried very hard. I think that I had some tears in my eyes also.

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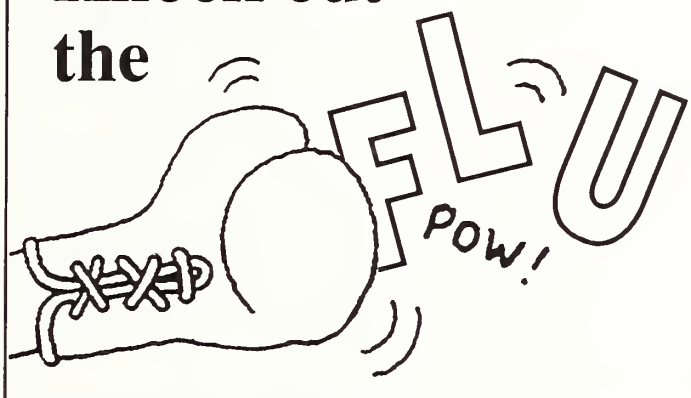

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Utilizing an epidemiological profile for HIV prevention community planning in West Virginia

GINAMARIE FOGLIA, D.O., M.P.H.
Fellow, Rural STD/HIV Prevention Fellowship, Section of Infectious Diseases, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown

R. WESLEY FARR, M.D.
Director, Rural STD/HIV Prevention Fellowship, Section of Infectious Diseases, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown

Abstract

An epidemiologic profile revealed that approximately 1,000-1,600 persons in West Virginia are living with HIV, and that it is the 5th leading cause of death among persons ages 25-44. HIV is also the leading cause of death in black males ages 25-44 in WV, and blacks are disproportionately affected by HIV/AIDS (composing about 3.1% of the general population and 17% of the AIDS population). This is most marked in Kanawha, Raleigh, and McDowell counties. The predominant mode of exposure reported from 1984-1993, and more recently from 1991-1993, has been men having sex with men (MSM), accounting for 57% of all AIDS cases. A substantial proportion of all cases (13%) were attributed to injecting drug use (IDU), especially in Public Health District 1 where 63% of women infected with HIV reported IDU as a risk behavior. It is difficult to draw conclusions about populations at risk in WV because of the large proportion of HIV cases reported without risk behaviors (26.5%). However, among men, most cases initially reported without risk are eventually reclassified to the MSM and IDU categories. Among women, most cases first reported without risk are eventually changed to the IDU and heterosexual contact categories. Map analyses by Public Health District and county suggest some clustering of cases in the southern region of the state which may be secondary to racial/ethnic and sociodemographic factors.

Introduction

An epidemiologic profile (1) was compiled to provide a thorough understanding of the HIV/AIDS epidemic among West Virginia populations to identify characteristics of HIV-infected persons in defined public health districts who need prevention services.

The following four key questions were addressed in the profile:

1. The sociodemographic characteristics of the population
2. The impact of HIV/AIDS on the population
3. Who is at risk of becoming infected with HIV
4. The geographic distribution of HIV infection

In the absence of a cure or definitive treatment, the best hope of curtailing the HIV epidemic still depends on our ability to educate the public about transmission risk behaviors in West Virginia through targeted intervention programs.

Methods

Data were obtained from the West Virginia Bureau for Public Health HIV/AIDS Reporting Surveillance System which included HIV and AIDS cases diagnosed from 1984-1993. HIV/AIDS cases diagnosed after 1993 were not included in this profile to compensate for an average six-month delay from the diagnosis to actual reporting by health care professionals (2).

AIDS and HIV became reportable by law in West Virginia in 4/84 and 1/89 respectively. AIDS case data are the only HIV-related data consistently available on a population-wide basis in all states by sex, race/ethnicity, age, and mode of HIV exposure. The severity of illness, combined with active surveillance of AIDS cases produce a data set that tends to be very complete.

Completeness of reporting means that AIDS cases we know about in West Virginia are representative of all persons with AIDS in West Virginia including the small proportion of cases not diagnosed and reported. HIV and AIDS cases are counted in the state of residence at the time of diagnosis. Thus, West Virginia figures do not reflect cases diagnosed out of state before moving to West Virginia.

Results

Since it was very important to establish confidentiality and prevent inadvertent disclosure of a person's identity, HIV/AIDS cases were enumerated by Public Health District (PHD) and county. In West Virginia, there are eight Public Health Districts which include 55 counties.

According to 1990 Census data (3), West Virginia has a total population of 1,793,477 (861,731 males and 931,746 females). The population is predominantly white (total white 1,726,023 or 96.3%; total non-white 67,454 or 3.7% of population). Blacks comprise the majority (83.7%) of the non-white population.

Compared with other counties in West Virginia, Clay, McDowell, Webster, Lincoln, and Gilmer counties have the largest number of people living below the poverty level. Census data reveal that 345,093 (19.7%) of West Virginians were living below the poverty level in 1990. Unemployment was highest in McDowell, Clay, Webster, Wyoming, and Lincoln counties compared with a statewide unemployment percentage of 9.6.

HIV/AIDS impact

There were 456 AIDS cases diagnosed from 1984-1993 and the distribution among the eight Public Health Districts roughly parallels the distribution of the districts' general population (Tables 1 & 2).

Approximately 7.8 men were diagnosed with AIDS for each woman. Although minority groups represent less than 4% of the general population, they comprise 17% of the AIDS population and 33% of the female AIDS population. For the most recent three-year period (1991-1993), AIDS cases reported accounted for 53% of the total number of AIDS cases in the state.

Drawing conclusions about exposure categories reported for AIDS and HIV cases among men and women is difficult because a high proportion of cases reported no identified risk behavior, especially in the HIV population (Tables 3 & 4). In general, the predominant mode of exposure among men was MSM, and among women IDU/heterosexual contact. PHD1 had the highest number of AIDS and HIV cases reported with IDU as a risk behavior. Thirty-seven percent of the state's HIV-only cases in women are from PHD1 and 63% of women who report IDU as a risk behavior for HIV also come from PHD1 and are predominantly black (80%).

The reported rate of AIDS cases (# per 100,000 population) among all AIDS cases in West Virginia was 4.51 in 1991, 4.68 in 1992 and 4.35 in 1993. These rates are much lower than the national rate of 30 in 1994 (4). Noteworthy, is the higher rate (as high as 25 in 1993) in non-whites (mainly blacks) when compared to whites in the state. Non-white rates, on average, are five times higher than rates in whites nationally.

TABLE 1. Distribution of AIDS Cases Diagnosed 1984-1993 by Public Health District

District	# AIDS Cases	% of Total AIDS Cases	% Gen. Population
1	56	12.3	13
2	74	16.2	15
3	98	21.5	16
4	35	7.7	8
5	34	7.5	9
6	45	9.9	9
7	57	12.5	20
8	57	12.5	10
WV	456	100	100

TABLE 2. Distribution of HIV Cases Diagnosed 1989-1993 by Public Health District

District	#HIV Cases	% HIV Cases	% General Population
1	56	20.6	13
2	36	13.2	15
3	63	23.2	16
4	11	4.0	8
5	13	4.8	9
6	13	4.8	9
7	57	21.0	20
8	23	8.4	10
Total	272	100	100

In 1993, HIV was the 5th leading cause of death among all people aged 25-44 in West Virginia. While HIV was the 6th leading cause of deaths among whites aged 25-44, it ranked as the leading cause of death among blacks in that age group.

Crude estimations of HIV prevalence were calculated based on two methods recommended by the CDC (5). Estimates, which lack precision because they are based on relatively small numbers, suggest that approximately 1,000 to 1,600 people are currently infected with HIV in West Virginia.

Individuals at high risk

Men and women most likely to become infected with HIV are those who engage in high-risk behaviors in communities in which there is a high prevalence of HIV infection.

A. Sexually Transmitted Disease (STD) in WV (6).

Persons with STDs represent a group of sexually active persons who have recently had unprotected intercourse with other persons who have STDs, some of whom may also be infected with HIV. The extent to which the STD rates correlate with HIV rates depends upon the prevalence of HIV infection in the community and on the local

patterns of STD transmission. STD rates may be an imperfect surrogate marker for HIV risk, but they are a reliable indicator of risky behavior (unprotected sex). Communities with a high STD rate are potentially at increased risk for the introduction and spread of HIV infection.

In 1993, there were 12 cases of primary and secondary syphilis, corresponding to a rate of .67/ 100,000. There were also 717 cases of gonorrhea and 1,945 cases of other STDs reported in West Virginia in 1993. The number of cases of gonorrhea and other STDs are highest in PHD3, as is the total number of AIDS cases.

B. Youth Risk Behavior Survey (YRBS) 1993 (7).

The WV Department of Education Youth Risk Behavior Survey was an 84-item, multiple choice survey given to 2,818 students in 36 public high schools in West Virginia during the spring of 1993. The overall response rate was 84% and the results can be used to make inferences concerning the major health risk behaviors of West Virginia high school students in grades 9 -12:

The survey revealed the following:

1. 63% of students reported having had sexual intercourse.
2. 50% of students reported using a condom during their last sexual intercourse (within the past three months).
3. 87% of students reported they had been taught about HIV/AIDS in school.
4. 18% of the male and 6% of the female students reported having had sexual intercourse for the first time prior to age 13.
5. 22% of students reported having sexual intercourse with more than four people.
6. 16% of male and 11% of female students reported drinking alcohol or using drugs before their last sexual intercourse.
7. 3% of respondents had been told by a health care professional that they had had an STD.

Table 3. AIDS Cases by Sex and Exposure Category from 1984-1993.

Exposure	Male #	Male %	Female #	Female %	Total #	Total %
MSM	258	64	0	0	258	57
IDU	44	11	16	31	60	13
Homosexual/IDU	24	6	0	0	24	5
Heterosexual/IDU	7	2	10	19	17	4
Transfusion	23	5	8	15	31	7
Heterosexual/HIV/AIDS	4	1	6	12	10	2
Heterosexual/Bisexual Male	0	0	2	4	2	0.5
Heterosexual/Transexual	0	0	2	4	2	0.5
Other	20	5	5	9	25	5
NIR	24	6	3	6	27	6
Total	404	100	52	100	456	100

Table 4. HIV Cases by Sex and Exposure Category from 1989-1993.

Exposure	Male #	Male %	Female #	Female %	Total #	Total %
MSM	106	53	0	0	106	39
IDU	18	9	24	34	42	15.5
Homosexual/IDU	8	4	0	0	8	3
Adult Hemophiliac	6	3	0	0	6	2
Heterosexual/HIV/AIDS	3	1.5	9	12	12	4
Heterosexual/Bisexual Male	0	0	5	7	5	2
Heterosexual/IDU	4	2	7	10	11	4
Heterosexual/Transexual	0	0	1	1.5	1	0.5
Heterosexual/Hemophiliac	0	0	1	1.5	1	0.5
Other	5	2.5	3	4	8	3
NIR	51	25	21	13	72	26.5
Total	201	100	71	100	272	100

National YRBS data (8) shows that in 1993, over 53% of the high school students have ever had sexual intercourse, nearly one in five (18.8%) have had four or more sexual partners, and almost half (47.2%) of the sexually active students did not use a condom at last sexual intercourse. From 1991-93, the percentage of high school students who had ever had sexual intercourse remained constant. However, at the same time, condom use at last intercourse increased from 46.2% to 52.8%.

C. HIV Seroprevalence Among Applicants for the Military

All applicants for military service (primarily individuals between the ages of 17-29), are screened for HIV. Data from the Dept. of Defense (9) available through CDC, may be used to chart trends in seroprevalence among adolescents/adults applying for the military. From 10/85-12/93, 40,278 West Virginians were screened for HIV infection, and 16 tested positive (2 women, 14 men) for a total seroprevalence of .04%.

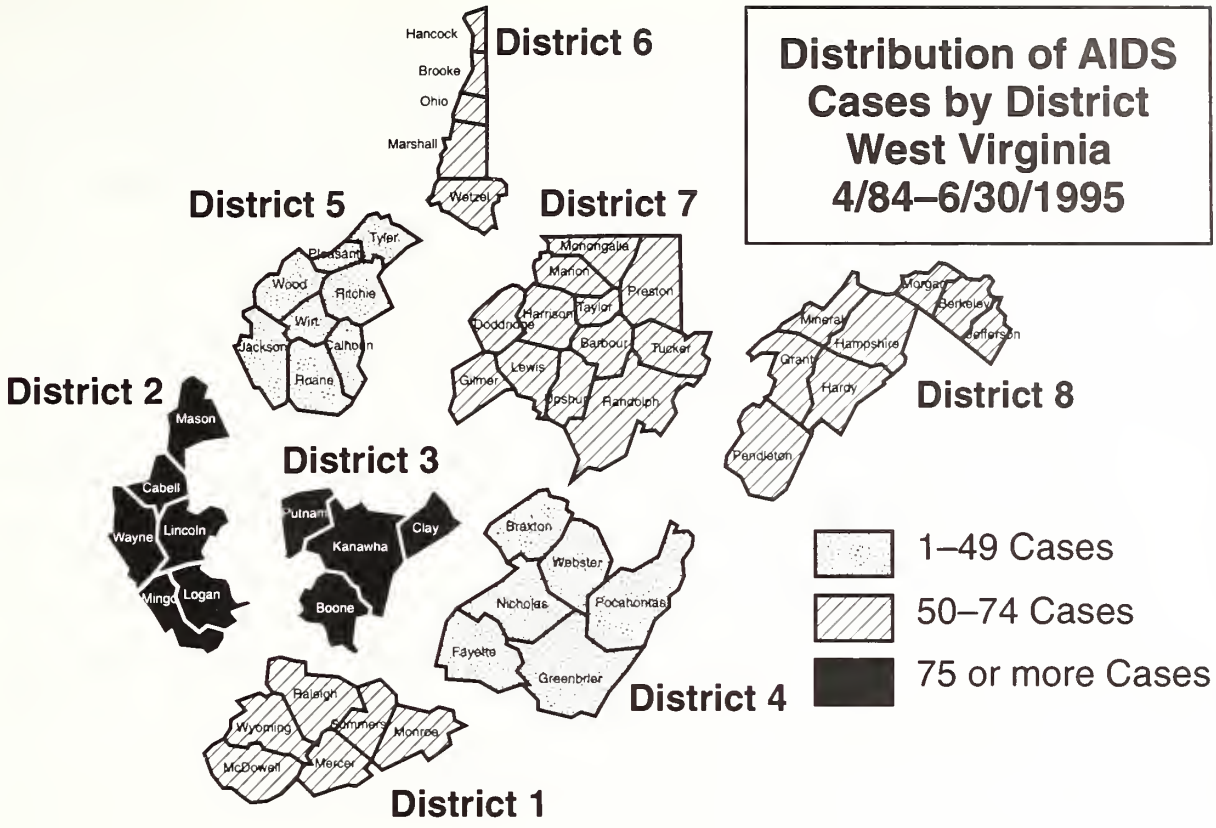

Figure 1. Distribution of AIDS Cases in West Virginia by Public Health Districts in WV from 1984-1995.

Thirteen were in the 17-29 year age group and the other three were in the 30+ age group.

Since drug use and homosexuality are grounds for exclusion from military service and applicants are thus counseled prior to being screened, seroprevalence rates among applicants for the military likely underestimate the seroprevalence of the general population.

D. Childbearing Women

The survey to estimate the rate of HIV infection among childbearing women was conducted in 44 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands in collaboration with CDC, the National Institute of Child Health and Human Development, and state and territorial health departments. This survey began in most states in 1988/89 and continued until 12/94, and it was based on the systematic, unlinked testing for HIV antibody of residual blood specimens routinely collected on filter paper from newborn infants for metabolic screening (10).

Consecutive births during a survey period of a least three months per year were sampled in each state. A positive test reflected HIV infection in the mother, but not necessarily the infant, because maternal antibodies cross the placenta during pregnancy. Results showed that approximately 15%-30% of infants born to HIV-infected mothers become infected with HIV.

The survey revealed that from 10/89 to 12/94, 114,498 infants were tested who were born to women living in West Virginia at the time of their delivery. Of these, 38 or .038% have been positive (14 positives are from PHD1). Due to the fact that these data are unlinked from any personal information that would identify the mother of the infant, we do not know what proportion of these women knew that they were infected with HIV nor how many were receiving zidovudine, which has been shown to decrease the risk of HIV transmission from an HIV-infected woman to the fetus (11). In addition, since the Survey in Childbearing Women is restricted to women who deliver live infants, the data cannot be generalized to all pregnant women.

Counseling of pregnant women and voluntary HIV testing is strongly encouraged because treatment is available to reduce perinatal HIV transmission.

Geographic Distribution of HIV

Figure 1 maps the 456 AIDS cases which occurred from 4/1984-6/30/95 in West Virginia by county/public health district. In addition, the total number of HIV cases which were reported in the state during this time period are illustrated in Figure 2.

There seems to be a clustering of AIDS cases in Southern West Virginia.

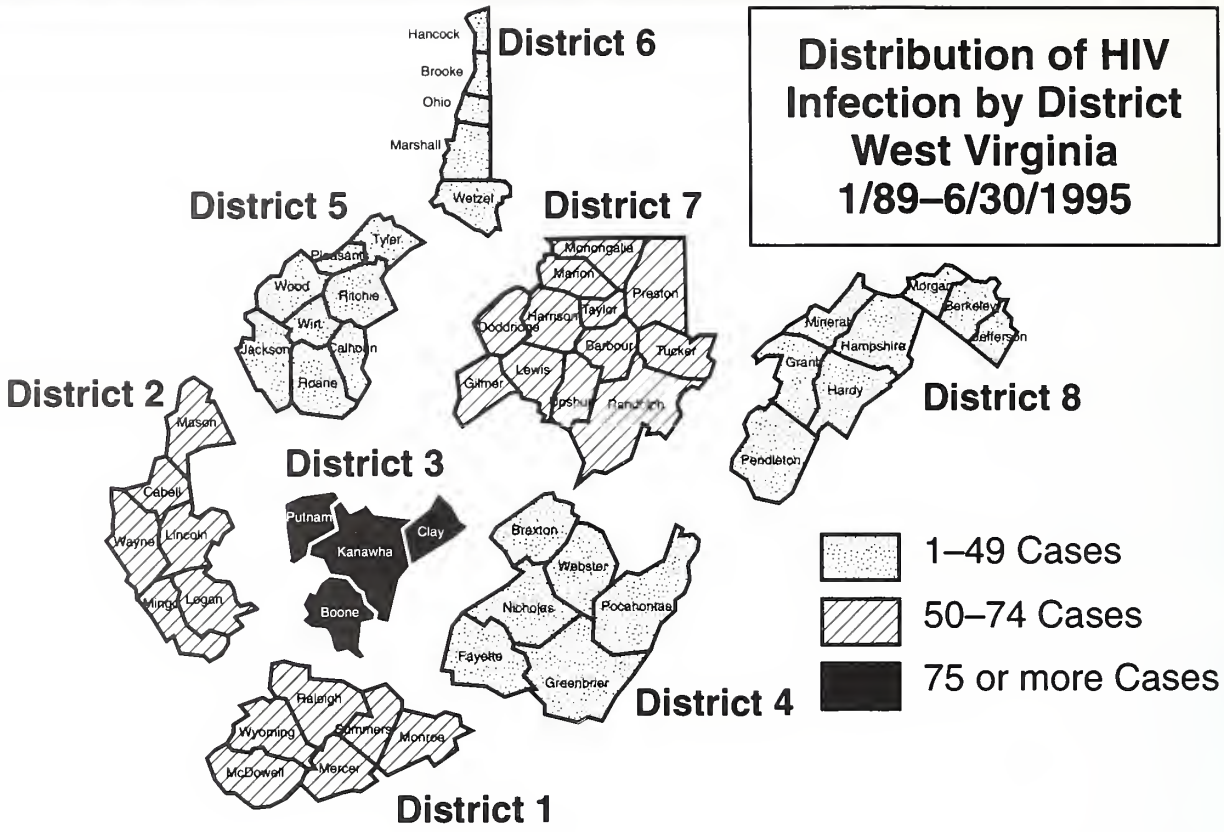

Figure 2. Distribution of HIV Infection by Public Health Districts in WV from 1984-1995.

Caution must be exercised when making conclusions about data that are mapped to small geographic areas. Very high rates may be based on very small numbers of cases in areas with low population. At times, the clustering of cases may not be apparent when district rates are mapped; however, clustering becomes apparent when the number of cases per county are considered.

The data in Figures 1 and 2 is cumulative and includes all cases ever diagnosed among persons who resided in any one of the counties/PHD at the time of diagnosis. The maps do not exclude persons who have died or moved.

Conclusion

An epidemiologic profile was compiled to provide a thorough understanding of the HIV/AIDS epidemic from 1984 - 1993 among various West Virginian populations and to identify characteristics of HIV-infected persons in defined public health districts who need prevention services.

Although West Virginia may rank 5th among states showing the lowest population of HIV/AIDS cases in the nation, we still have approximately 1,000 - 1,600 people living with HIV and that number continues to increase secondary to continued high-risk behaviors. A 1997 epidemiologic profile noted that 723 AIDS cases have been reported from 1984 through 1996 and 411 HIV infections have been reported from 1989 through 1996 (12). The predominant risk behavior for HIV continues to be MSM among men followed by IDU, whereas, in women, the predominant risk behavior is heterosexual contact and/or IDU.

Comparing the periods of 1989-1992 with 1993-1996, the proportion of cases who are females increased from 10% to 13%. To date, females account for 13% of the reported AIDS cases and 27% of the HIV infections (12). In comparing the periods of 1985-88, 1989-92, and 1993-96, the proportion of AIDS cases associated with IDU has increased from 9% to 14% to 17%, and the proportion of cases attributed to heterosexual contact has increased from 5% to 7% to 9% (12).

There seems to be a clustering of HIV/AIDS cases in the southern region of the state which may be attributed to the racial/ethnic and sociodemographics features of the area. The epidemiology of HIV/AIDS in West Virginia is changing from the initial AIDS epidemic pattern in the United States (which primarily affected gay/bisexual men and drug users) to a second epidemic pattern that is affecting women and heterosexuals in rural areas. The transmission, progression, and health care pattern of these rural HIV cases have not been adequately studied. Therefore, West Virginia University Medical Center, in collaboration

with the West Virginia Bureau for Public Health, is conducting research to:

A. evaluate the relationship of high-risk behaviors with HIV transmission;
B. determine the source of HIV infection;
C. determine the travel/migration patterns of HIV-infected persons and their relationship to newly-infected cases;
D. evaluate barriers to care in rural areas; and
E. determine the availability and utilization of HIV-prevention messages and services during and before the estimated time of HIV infection in the southern region of West Virginia.

The long-term objective will be to develop appropriate intervention in areas of education, prevention, and health care delivery in a rural setting. Since funding for HIV/AIDS prevention and medical services granted through the Centers for Disease Control and Prevention is solely dependent on the number of HIV/AIDS cases reported, all health care providers are urged to timely report all HIV/AIDS cases to the West Virginia Bureau for Public Health promptly so that we can better estimate the impact that HIV/AIDS on our population. In addition, health care providers can learn more about the epidemiology, management and prevention of HIV/AIDS by attending courses at the Mid-Atlantic AIDS Education and Training Center at the West Virginia University Medical Center; phone (304) 293-1949.

In the absence of a cure or definitive treatment, the best hope of curtailing the HIV epidemic remains educating the public about transmission risk factors in West Virginia through specifically targeted intervention programs.

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11037-J98

Schedules for Clinical Assessment in Neuropsychiatry (SCAN): Introduction to WV's mental health community

AHMED ABORAYA, M.D., Dr.P.H.
Assistant Professor of Psychiatry, Department of Behavioral Medicine and Psychiatry, West Virginia University School of Medicine, Morgantown

ALLEN TIEN, M.D., M.S.
Adjunct Professor, Department of Behavioral Medicine and Psychiatry, West Virginia University School of Medicine, Morgantown

JAMES STEVENSON, M.D.
Professor of Psychiatry and Chairman, Department of Behavioral Medicine and Psychiatry, West Virginia University School of Medicine, Morgantown

KERR CROSBY
Conference Coordinator, West Virginia University School of Medicine, Morgantown

Abstract

The Schedules for Clinical Assessment in Neuropsychiatry (SCAN) is a semi-structured clinical interview used by trained clinicans to assess and diagnose psychiatric disorders among adults. The SCAN core is the Present State Examination (PSE) which has been developed and tested globally during the past four decades with good validity and reliability. The SCAN was developed within the framework of the World Health Organization (WHO) and the National Institute of Mental Health (NIMH) Joint Project on Diagnosis and Classification of Mental Disorders, Alcohol and Related Problems (1). The use of the SCAN gives the flexibility to diagnose mental disorders based on the current International Classification of Disease (ICD), Diagnostic and Statistical Manual (DSM) systems or other diagnostic systems that may develop in the future. A major purpose of the SCAN is to allow comparisons of psychiatric diagnoses to be made across the world.

Introduction

In using the SCAN, psychiatric symptoms are measured by asking respondents questions representing certain defined clinical phenomena. The clustering of certain symptoms, along with measures of severity and level of function, constitute the diagnostic criteria for most mental disorders (2,3).

This paper describes advances in the scientific measurement of psychopathology utilizing the SCAN.

Historical review

Psychiatric interviews can be structured or unstructured based on the clinician's speciality, interest, and training. The systematic use of structured interviews began in the 1950s in Europe, and in the United States almost at the same time.

One of the psychiatric interviews which was created in the 1950s in Europe was the Present State Examination (PSE). It was designed to assess the patient's psychiatric state at the time of the interview and during the previous month (4).

The PSE has now been refined to its 10th version and been used in several international studies (5,6,7,8,9). The PSE has shown good reliability as a psychiatric instrument (10,11,12), and the Schedules for Clinical Assessment in Neuropsychiatry (SCAN) is the latest stage of almost four decades of refinement of the PSE.

The use of structured clinical interviews minimizes information variance, observation and interpretation variance and criterion variance. Information variance can be minimized by covering all relevant areas of psychopathology, observation and interpretation variance can be minimized by standardized training of the interviewers, and criterion variance can be minimized by using specific diagnostic criteria (13). In addition, the use of structured interviews allows the utilization of inclusion and exclusion criteria of mental disorders and improves the reliability of diagnoses of mental disorders (19).

Two main diagnostic systems developed after World War II: the International Classification of Diseases (ICD) by the WHO, and the Diagnostic and Statistical Manual (DSM) by the American Psychiatric Association (APA). Although there were some differences and criticisms of both systems in the 1960s, the two systems are becoming more similiar in diagnostic criteria. For example, the criteria for schizophrenia are the same except the requirements of a duration of six months by DSM (compared with only one month for ICD) and of deterioration in functioning by DSM (not required by ICD)(15).

An optimistic view by Dittman (16) predicts one internationally accepted classification of mental disorders by the end of this century. One of the main goals of the SCAN is to provide a flexible system that can generate diagnoses based on the ICD, DSM or any other diagnostic criteria that may develop in the future.

SCAN development

The SCAN was created within the framework of the WHO and NIMH Joint Project on Diagnosis and Classification of Mental Disorders, Alcohol and Related Problems through these three phases (1):

1982-1990: Development and field trials of a pilot version.
1990-1992: Revision for change in ICD-10 DCR. Production of a printed prepublication SCAN Version 1, WHO, Geneva.
1992-1994: Updating to incorporate the final version of ICD-10 DCR and DSM-IV items and algorithms. Publication of SCAN Version 2.

We might add the fourth phase from 1994 to present to include the publication of Version 2.1 and the development of the computer program of the SCAN.

Data from the international field trials of the SCAN shows high reliability for schizophrenia, bipolar affective disorders, depression, phobia and the use of alcohol (17).

Structure of the SCAN

The SCAN is composed of the Manual and Glossary. The SCAN Manual contains three components: the 10th version of the Present State Examination (PSE 10), the Item Group Checklist (IGC), and the Clinical History Schedule (CHS). Table 1 shows the sections of the PSE 10.

The SCAN Glossary contains precise definitions of most of the items of the Manual. The Glossary is the phenomenologic core of the SCAN (18) with which the interviewer should be familiar. The computer program can provide quick access to the Glossary during the interview.

Table 1. Sections of the Present State Examination (PSE 10).

	Part I
Section 1	Introduction
Section 2	Somatoform and Dissociative Symptoms
Section 3	Worrying and Tension
Section 4	Panic, Anxiety, and Phobias
Section 5	Obsessional symptoms
Section 6	Depression and Dysthymia
Section 7	Thinking, Concentration, Energy, and Interests
Section 8	Bodily Functions
Section 9	Eating Disorders
Section 10	Expansive Mood and Cyclothymia
Section 11	Alcohol
Section 12	Psychoactive Substances
Section 13	Stress and Adjustment Disorders
Section 14	Screening for Part II
Section 15	Language Problems
Section 16	Perceptual Disorders other than Hallucinations
Section 17	Hallucinations
Section 18	Experiences of Disorders of Thought and Replacement of Will
Section 19	Delusions
Section 20	Course of Schizophrenia and Other Psychoses
Section 21	Cognitive Impairment
Section 22	Motor and Behavioral Items
Section 23	Affect
Section 24	Speech Abnormality

Principles of Utilizing the SCAN

1. The SCAN interview is semi-structured. The interviewer has the flexibility to start with any section if she/he thinks that particular section is more pertinent. The interviewer may return to the rest of the sections as the interview goes on.
2. Each section has screening questions and cut-off points to allow the rest of the questions in a section to be skipped, if the screening questions do not elicit evidence for abnormality in the area. However, the interviewer can and should continue the rest of the section if there is any evidence that the patient might have symptoms in the section.
3. The SCAN items have main probe and sub-probe questions. The interviewer asks the main question at minimum and has the flexibility to ask more of the probe questions to get the right answer.
4. The respondent's yes or no responses to an item are not the clinical answer. The interviewer uses clinical experience and judgment skills to make the final decision, within the SCAN definition of the items.
5. The **severity of the clinical phenomena** is assessed by three levels (mild, moderate, or severe) for most of the items.
6. The SCAN has an optional **attributional scale** which describes suspected causes of symptoms such as drugs or medical problems.
7. The paper version of the SCAN allows the recording of two episodes such as the present state (the past month) and a representative episode. Up to six special episodes can be coded on the paper version.
8. The computer program of the SCAN allows the flexibility of recording **unlimited episodes** and dating onset and offset.
9. The SCAN uses the **bottom-up approach** by focusing on the assessment of the items of psychopathology without consideration of possible diagnoses (22). Collecting data with the bottom-up approach allows the ability to make diagnoses based on the ICD, DSM, or any other criteria.
10. The SCAN uses the principle of **clinical cross examination**. Questions and probe questions are asked and the interviewer compares the respondent's answer with the defined concepts in the SCAN glossary. Ratings of the questions are made when the evidence, in the judgment of the SCAN interviewer, matches the defined concepts. The standardized definition of these concepts throughout the world is the main purpose of the SCAN.

Conclusions

The SCAN represents the latest stage of four decades of experience in the science of measurement of psychological phenomena. A computer version of the SCAN is available which supports interviewing, allows data entry, and provides data in a convenient form for research. This SCAN computer program will help to link clinical information and its use in research (19).

There are three SCAN centers in the United States: at Johns Hopkins University in Baltimore, Md.; at Washington University in St. Louis, Mo.; and at the University of Connecticut in Farmington, Conn. Located at West Virginia University (WVU) is the newest developing SCAN Training and Reference Center following the WHO guidelines.

Scan workshops for mental health professionals are offered by the Department of Behavioral Medicine and Psychiatry at WVU. For more information about SCAN workshops, call Kerr Crosby at (304) 293-2637.

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The treatment of breast cancer in the elderly: A community hospital experience

STEVEN J. JUBELIRER, M.D.
Clinical Professor of Medicine, West Virginia University Medical Center, Charleston Division; and Senior Research Scientist, Camcare Health Education and Research Institute, Charleston

CRISTOFORO R. LARZO
Research Extern

Abstract

The physician's dilemma in choosing the optimal management for breast cancer in the elderly arises from long-held beliefs that elderly patients 1) have a limited life expectancy from comorbid conditions other than breast cancer and 2) do not tolerate standard treatment. To determine if these beliefs were indeed reflective of the clinical behavior of breast cancer in the elderly, we reviewed the hospital and tumor registry records of 182 women age 70 years and older who received treatment for locoregional invasive breast cancer (Stage I and II) at CAMC between 1977 and 1987. The median time interval between diagnosis and last contact or death was 82 months. Actuarial survival was calculated on the basis of this interval Statistical Analysis System (SAS). Eighty-five percent of patients underwent mastectomy and 15% had breast conservation surgery. There was only one postoperative death. Forty-eight (26%) of 182 patients received systemic adjuvant therapy. The breast cancer-specific survival rate of all patients in this study was 84% at five years and 71% at 10 years. The 5-year and 10-year breast cancer specific survivals were 94% and 86% for stage I patients respectively and for stage II patients the five-year and 10-year survivals were 74% and 56% respectively. Our results indicate that the majority of elderly women with breast cancer can tolerate standard surgical therapy and survive disease-free for many years.

Introduction

One in eight women in the United States is at risk of having breast cancer in her lifetime. The probability of developing breast cancer is highest in older women.

Data from the Surveillance Epidemiology, and End Results (1) (SEER) study revealed that for women 80-84 years of age, the breast cancer incidence is as high as 435 cases per 100,000; in contrast, the incidence is 212 per 100,000 in women 50-54 years of age. By the year 2030, it is estimated that almost two-thirds of patients with breast cancer will be age 65 or older (2).

Despite the dramatic increase in the size of the aged American population and the marked increase in the incidence of breast cancer with age, there has been a trend toward less aggressive management of cancers in older women (3). Until recently, older patients, especially those over 70-years-old, frequently were excluded from clinical trials.

Physicians face the dilemma of how aggressively or conservatively to treat elderly patients with breast cancer in order to achieve the greatest benefit. This dilemma arises from two beliefs which have been long-held in the medical community about elderly patients:

1. have a limited life expectancy from comorbid conditions other than breast cancer; and
2. do not tolerate standard therapy, e.g. surgery or radiotherapy.

To determine whether these beliefs were actually reflective of the clinical behavior of breast cancer in the elderly, we reviewed the medical records and Tumor Registry records of 182 women age 70 years and older, who were diagnosed and treated at Charleston Area Medical Center (CAMC) between 1977 and 1987.

Methods

We analyzed the medical records and Tumor Registry records of women age 70 and older who were referred from 1977 to 1987 to CAMC for definitive treatment for early-stage (stage I and stage II) breast cancer.

The median time interval between diagnosis and last contact or death was 82 months. Actuarial survival was calculated on the basis of this interval (SAS Windows application). The stage at presentation, response to surgery, comorbid conditions, and survival rates were obtained for each patient.

Results

A. Clinical/Histologic Presentation

The most frequent comorbid conditions under active treatment at the time of diagnosis were cardiovascular disease (40%), diabetes mellitus (29%), arthritis (24%) and hypertension (23%). Ninety percent of patients were totally mobile; two or more comorbid conditions were present in 35%.

Fifty-two percent had primary tumors of 2 cm or smaller (T_1), 46% had tumors ≤ 2 cm (T_1), 46% had tumors > than 2 cm but ≤ 5 cm (T_2), and 2% had tumors > 5 cm. In addition, 180 patients had an axillary lymph node dissection; histologically positive lymph nodes were found in 51 (28%) of these patients. Using the current American Joint Commission Cancer Staging System, 66% of patients had stage I disease ($T_0N_0M_{0)}$ and 34% had stage II disease (T_1N_1; T_2N_{0-1}; T_3N_{0-1}).

Infiltrating ductal carcinoma was the predominant histologic type (88%). Other histologic types were noted in 22 patients (infiltrating lobular 10; colloid or mucinous 7; and papillary 5). Of the 127 women with known estrogen receptor status, 75% were receptor positive.

B. Treatment

Total mastectomy with axillary node dissection was performed in 85% of patients. Only 28 patients had breast conservation surgery. One patient died four days postoperatively from a myocardial infarction.

Only 10% of the patients had complications after surgery. The most common complications were wound infection and wound hematoma/seroma. Twenty-seven patients underwent radiotherapy following breast-conserving surgery. Complications were recorded in fewer than 5%. The most common complications were fatigue, skin erythema, and transient radiation lung changes.

Adjuvant therapy was employed in 48 patients (26%); Tamoxifen in 31 patients, and chemotherapy in 17. Eighty-one percent of those receiving adjuvant therapy had positive lymph nodes.

C. Clinical Outcomes

The breast cancer-specific survival for all patients was 84% at five years and 71% at 10 years. The 5- and 10-year breast cancer-specific survival was 94% and 86% respectively for stage I patients and 74% and 56% respectively for stage II patients.

Over a 17-year follow-up period in which living patients have been observed for a mean of 115 months, there have been 96 deaths. Forty-five percent of these deaths were from breast cancer and 55% from other causes. The most common known cause of non-cancer-related death was cardiovascular disease.

Discussion

Numerous studies have indicated that healthy elderly patients can tolerate expeditious mastectomy with an operative risk similar to that of younger patients. Turnbull et al (4) demonstrated in an analysis of 4050 operations that the operative mortality rate of patients older than 70 years (4.8%) was similar to that of younger patients (3.4%).

Herbsman et al (5) published a analysis of 1,780 patients who underwent surgery, 138 of whom were age 70 years or older. No excess mortality from surgery was noted in the older patients. Hunt et al (6) showed that the average mortality rate in older patients undergoing mastectomy was less than 1%. A similar finding was reported by Amsterdam et al (7). In our study, there was only one postoperative death, and the rate of morbidity (10%) was low, mainly related to short-term wound complications.

The lack of significant difference in breast cancer disease-free survival and overall survival between older and younger patients has been emphasized in several recent studies. In the study by Masetti et al (7), 190 patients age 70 years or older treated for breast cancer were compared with 190 younger patients and matched on the basis of T and N categories (TNM staging system) and surgical procedures. The 10-year actuarial overall survival and disease-free survival was similar in both the older and younger groups.

Solin et al (9) compared elderly women (65 years of age or older) vs. those ages 55 to 64 years with stage I or II breast cancer treated similarly with breast-conserving surgery and definitive irradiation. There were no differences between the two age groups in the 10-year rates of overall survival (77% vs. 85%), relapse-free survival (64% vs. 70%), freedom from distant metastases (83% vs. 78%), or local failure (13% vs. 12%).

Several studies have reported the use of tamoxifen as initial therapy rather than surgery for operable breast cancer in elderly patients (10,11). Robertson et al (10) noted that with surgery 70% were free of local disease; whereas, with tamoxifen therapy alone, only 47% remained free of local disease. Bates et al (11) showed no difference in survival or quality of life between optimal surgery and tamoxifen therapy, but those treated with tamoxifen alone more frequently had a subsequent change in management - usually surgery for local treatment failure. These results suggest that tamoxifen alone can be justified only in those patients where high-grade comorbid conditions contraindicate appropriate surgical treatment.

Our study, in addition to others, has refuted the assumption that elderly patients' treatment should be limited to less aggressive therapy. There was only one postoperative death and the 5- and 10-year breast cancer specific survivals were 84% and 71% respectively. Although some elderly women may have comorbid conditions, treatment should be individualized for each patient.

Several epidemiologic studies have estimated that a woman at the age of 70 has a life expectancy of more than 15 years; at the age of 80, she is expected to live an additional seven years (12,13,14). Thus, many older patients will live long enough for the cancer to recur locally if they are under-treated. Treatment, therefore, should be guided by an acceptable individual benefit/risk ratio to provide optimal quality and quantity of life.

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At Mid-Winter

Second Session to discuss controversies about acute pediatric otitis media, alternative medicine

This year's Second Scientific Session on *"Controversies in Medicine"* at the WVSMA's Mid-Winter Clinical Conference will feature two lectures discussing the management of antibiotic treatment of acute pediatric otitis media, and a presentation on alternative medicine. This session is scheduled for Saturday, January 23 at 9 a.m. at the Embassy Suites, which will be the site for all Mid-Winter Clinical Conference events.

This session will begin with a lecture by **Robert E. Pollard, M.D.**, an otolaryngologist at The Eye & Ear Clinic of Charleston Inc., concerning *"Controversies in Management of Acute Otitis Media."* Immediately following, **Kenneth M. Grundfast, M.D., F.A.C.S., F.A.A.P.**, of the Georgetown University Medical Center in Washington, D.C., will discuss *"Toward Judicious Use of Antibiotics in Management of Otitis Media."*

After a break, this session will focus on controversies regarding alternative medicine with a lecture by **Tara C. Sharma, M.D., F.A.C.S.**, F.I.C.S., chief and clinical associate professor of the Division of preventative and integrative medicine at Marshall University. Dr. Sharma's presentation is *"It Doesn't Have to Be Either Or."*

A preliminary agenda, registration form and other information about this year's meeting is published in this issue of the *Journal* beginning on page 336. If you need further details, phone the WVSMA at (304) 925-0342. To contact the Embassy Suites for room reservations, dial 1-800 Embassy or 347-8700.

Pollard

Grundfast

Sharma

Speakers highlighted

Dr. Pollard received his medical degree from Georgetown University in 1984. He interned at Portsmouth Naval Hospital and served as senior medical officer at the Naval Weapons Station in Yorktown, Va.

From 1987 to 1991, Dr. Pollard completed a residency in otolaryngology at the National Naval Medical Center in Bethesda, Md. He then relocated to Orlando, Fla., where he was an otolaryngologist at Orlando Naval Hospital for two years before accepting his current position as an otolaryngologist at The Eye & Ear Clinic of Charleston Inc.

A clinical assistant professor at the Robert C. Byrd Health Sciences Center of West Virginia University, Charleston Division, Dr. Pollard is also an instructor in pediatric advanced life support. He is certified by the American Board of Otolaryngology and is a member of the American Academy of Otolaryngology - Head and Neck Surgery, as well as the AMA, WVSMA and Kanawha Medical Society.

Dr. Grundfast is a native of Brooklyn who received his medical degree from the State University of New York at Syracuse in 1969. He completed an otolaryngology residency at Boston University and affiliated hospitals and a fellowship in pediatric otolaryngology at the Children's Hospital of Pittsburgh.

After serving as chairman of the Department of Otolaryngology at Children's National Medical Center in Washington, D.C. for 14 years, Dr. Grundfast accepted his present roles as interim chairman of the Department of Otolaryngology - Head and Neck Surgery and professor of otolaryngology and pediatrics at Georgetown University Medical Center in Washington, D.C. In addition, Dr. Grundfast is a clinical professor in the Department of Surgery for Uniformed Services at the University of the Health Sciences in Bethesda, Md.

Dr. Grundfast is a past president of the American Society of Pediatric Otolaryngology and of the Society

for Ear, Nose and Throat Advancements in Children. From 1994-96, he served as vice president of the American Academy of Otolaryngology - Head and Neck Surgery and was chairman of the Section on Otolaryngology and Bronchoesophagology of the American Academy of Pediatrics from 1992-94.

Dr. Grundfast has given more than 270 lectures and presentations, locally, nationally and internationally. He has published over 100 articles, reviews and book chapters and is the co-author of *"Ear Infections in Your Child"* and *"Pediatric Otology and Neurotology."*

Dr. Sharma was born in India and graduated from the Medical College of Amritsar in 1960 and then completed a rotating internship at V. J. Hospital in Amritsar. He did residency training in general surgery and general medicine at Irwin Hospital in New Delhi, where he also served as a medical officer and registrar in clinical pathology.

In 1963, Dr. Sharma came to the United States and completed a surgical internship and residencies in general surgery and urology at Washington Hospital Center in Washington, D.C. Following his residencies, Dr. Sharma moved to New York to serve as a special fellow in urological oncology at Memorial Hospital for Cancer and Allied Diseases.

Dr. Sharma is currently president of Huntington Urology, Inc. and an attending urologist at Cabell Huntington Hospital, St. Mary's Hospital and the Family Care Outpatient Center at the Marshall University School of Medicine. Active on the Marshall faculty, Dr. Sharma is a clinical associate professor in the Department of Surgery and a clinical associate professor and program director of the Division of Preventive & Integrative Medicine in the Department of Family and Community Health.

A fellow of the Royal Society of Health, the International College of Surgeons and the American College of Surgeons, Dr. Sharma is a past president of the West Virginia State Urological Society. He has published over 20 journal articles and lectured extensively locally, nationally and internationally on urology, surgery, preventive medicine and variety of other subjects.

Dr. Sharma's interest in alternative medicine was sparked by personal experiences that made him get involved in the search of alternative therapies for the past 15 years. In his practice, Dr. Sharma strives to incorporate ancient wisdoms with today's modern technologies to give the best of both worlds to patients.

Popular "Stump the Audience" segment set for Mid-Winter

Challenging case studies will be delivered by three physicians who will attempt to *"Stump the Audience"* during the Fourth Scientific Session on Sunday, January 24 at 10:30 a.m. during the WVSMA's Mid-Winter Clinical Conference at the Embassy Suites in Charleston.

Presenting the case studies for this popular event will be **James E. Brick, M.D.**, professor and interim chairman of the Department of Medicine at the WVU School of Medicine in Morgantown; **J. Gregory Rosencrance, M.D.**, associate professor and interim chairman of the Department of Medicine at the WVU School of Medicine in Morgantown; and **Kevin W. Yingling, R.Ph., M.D., F.A.C.P.**, program director of the Internal Medicine Residency Training Program at the Marshall University School of Medicine. **Warren Point, M.D.**, professor emeritus of the WVU School of Medicine, Charleston Division, and **Robert J. Marshall, M.D.**, a clinical professor of medicine for WVU and Marshall University will again act as the facilitators and present special door prizes at the conclusion of the case studies.

Brick

Rosencrance

Yingling

Prior to the start of *"Stump the Audience,"* three lectures are scheduled to be presented beginning at 9 a.m. First, **Margaret Kemeny, M.D.**, of Manhasset, N.Y., will lecture on the subject of *"Image Guided Breast Biopsies,"* and then **Mark Stephens, M.D.**, principal clinical coordinator of the West Virginia Medical Institute, and **Marsha Bailey, M.D.**, medical director for Corporate Health Services in Charleston, will discuss *"The Practical Use of Guidelines in Improving the Care of Patients with Low Back Pain in a Large Hospital."*

Bios on Drs. Brick, Rosencrance and Yingling begin on the next page, and information about Drs. Kemeny, Stephens and Bailey will appear in the January/February *Journal.* For more details about the Mid-Winter Clinical Conference, phone the WVSMA at (304) 925-0342. A preliminary agenda, registration form and other conference materials begin on page 336 in this issue.

Case presenters highlighted

Dr. Brick received his M.D. degree from WVU in 1977, and completed his internship and residency in medicine at WVU Hospital. After his residency, he did a fellowhip in rheumatology at WVU Hospital and began teaching at WVU.

From 1982-84, Dr. Brick continued his postgraduate studies at the University of Missouri in Columbia with a fellowship in immunology and rheumatology. He returned to WVU in 1984 and joined the Section of Rheumatology as an assistant professor. He advanced through the academic ranks to his present position as professor of medicine, and he currently serves as interim chair of the Department of Medicine.

Dr. Brick is board certified in internal medicine and rheumatology and is very active in research. He was medical director for Mountaineer Doctor Television (MDTV) at WVU from 1991-97 and presently serves on the editorial board for *Telemedicine Journal.*

Dr. Rosencrance obtained his medical degree from the Marshall University School of Medicine in 1988. He completed his internship and residency at Charleston Area Medical Center and then joined the faculty of the WVU School of Medicine, Charleston Division, as an assistant professor of medicine.

Dr. Rosencrance currently serves as an associate professor of medicine and interim chairman of the Department of Medicine at WVU's Charleston Division. In addition, Dr. Rosencrance is physician administrator of the University Practice Clinic and is medical director of the West Virginia Poison Center.

In the fall of 1996, Dr. Rosencrance was elected to fellowship in the American College of Physicians and he is active in many other medical organizations including the American Academy of Clinical Toxicology, the Association of Program Directors in Internal Medicine and the American College of Physician Executives. He was named Academic Attending of the Year for both 1995 and 1997 for the WVU School of Medicine, Charleston Division, and was named Clinician of the Year for 1996-97 for the Robert C. Byrd Health Sciences Center of WVU, Charleston Division.

Dr. Rosencrance is a volunteer for West Virginia Health Right and has been medical director for the Charleston Distance Run since 1993.

Dr. Yingling received a B.S. degree from the WVU School of Pharmacy in 1981 and then obtained his medical degree from the Marshall University School of Medicine in 1985. He completed an internship and residency in internal medicine at the University of Cincinnati Medical Center, where he also did a research fellowship in the Division of General Internal Medicine.

Following his fellowship, Dr. Yingling taught at the University of Cincinnati for a year and was a visiting scholar at the Cambridge University School of Clinical Medicine in Cambridge, England. In 1990, Dr. Yingling moved to Huntington to join the faculty of the Marshall University School of Medicine, where he currently is medical director of the Center for Pharmacologic Study, as well as program director of the Internal Medicine Residency Training Program and a consulting pharmacist.

During his career at Marshall, Dr. Yingling has twice received the Faculty Clinician of the Year Award and was named Professor of the Year for 1992-1993. He recently served as an honorary visiting academic fellow in clinical pharmacology for the Southampton University Hospitals Health Service Trust in Southampton, England.

A diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians, Dr. Yingling recently co-authored two chapters for the book *"Becoming a Physician - A Primer for Students,"* which is edited by Drs. Maurice Mufson and Shirley Neitch of Marshall University.

Physician/Public Session to focus on variety of domestic violences issues

"Violence in the Home Becomes Violence in the Streets" is the title of this year's Physician/Public Session at 7 p.m. on Friday, January 22 during the WVSMA's Mid-Winter Clinical Conference at the Embassy Suites in Charleston.

WVSMA President Dr. David Avery will moderate this session which will feature **Cindy W. Christian, M.D.**, assistant professor of pediatrics at the Children's Hospital of Philadelphia; **Sergeant Tom Westfall** of the Marshall County Sheriffs Department; and **Jerome D. Massenburg, M.D.**, of Charleston Psychiatric Group.

Dr. Christian received her M.D. from Albany Medical College in 1985. She completed an internship and residency in pediatrics, as well as a fellowship in child abuse and neglect at the Children's Hospital of Philadelphia.

After her fellowship, Dr. Christian joined the staff at Children's Hospital, where she is now an assistant physician and an assistant professor of pediatrics. In addition, she currently serves as a consulting pediatrician for the Supportive Adult Child Network in Philadelphia and is very active in a number of state agencies dealing with child abuse issues.

A fellow of the American Academy of Pediatrics, Dr. Christian is the co-organizer of the national Child Abuse Physician Leadership Conference and has written extensively on the subject of child abuse and neglect.

Sergeant Westfall is a 29-year veteran of the Marshall County Sheriff's Department in northern West Virginia.

During his career, Sgt. Westfall has served in every phase of law

enforcement and he is best known for his investigation of murder, child abuse and fraud surrounding the Hare Krishna commune in Marshall County. This case was chronicled in the book *"Monkey on a Stick,* which was written by *New York Times* reporter Lindsy Grunson. He received a commendation from the director of the FBI for his nationwide investigative effort on this case.

In 1994, Sgt. Westfall was selected to become one of the original law enforcement trainers on the subject of the police role in the prevention of domestic violence. Since then he has trained over 1,000 police officers and has created training programs for educators, social service workers and the medical profession. In October 1997, he was selected to represent West Virginia at a national conference on domestic violence in Albuquerque, N.M.

Massenburg

Dr. Massenburg received his M.D. from Meharry Medical College in Nashville in 1973. He interned in psychiatry at Winnebago Mental Health Institute in Winnebago, Wis., and then joined the U.S. Army and completed a residency in psychiatry at Walter Reed Army Medical Center in Washington, D.C.

From 1976-86, Dr. Massenburg held posts with the U.S. Army in Seoul, Korea, and in Fort Jackson, S.C. During this time, he also taught for two years at the University of South Carolina and in 1981 served as a consulting psychiatrist at Howard University Hospital.

Since 1986, Dr. Massenburg has practiced with Charleston Psychiatry Group, Inc. in Charleston. He also is currently the associate medical director for Carelink Health Plans and is the national on-call associate medical director for Magellan Health Services/Green Spring Health, Inc. in Columbia, Md.

Dr. Massenburg is a fellow of the American Psychiatric Association and is on the faculties of WVU and Marshall University.

Domestic Violence Workshop

Linda Cooper, R.N.-C.S., M.S.N., of the Family Resource Center at Women and Children's Hospital, interacts with participants during one of the breakout sessions at the conference on *"WV Health Partnerships: Improving Health Care Facilities' Response to Domestic Violence,"* in Charleston. The goal of this training was to provide employees at the various health care facilities in West Virginia with an understanding of domestic violence, clinical skills and planning time to enable them to improve their responses to patients suffering from acts of domestic violence. Nancie Albright of the WVSMA serves on the board of the WV Coalition Against Domestic Violence which conducted the training as part of a ten-state health project.

Medical Assurance ranked as a Forbes "Top 200" Company

Forbes Magazine has ranked Medical Assurance, Inc., the WVSMA's endorsed malpractice insurer, as one of *"The 200 Best Companies"* in American based on a number of financial measures that help assure policyholders of the company's financial strength.

Chairman A. Derrill Crowe, M.D., attributes MAI's debut on the Forbes' list to outstanding customer service and a dedication to financial strength. "By steadfastly living up to our moral and financial commitments to be an advocate for each insured, we have created a franchise that is unique in the insurance industry," he said.

For a copy of the article, call Medical Assurance at 800-331-6298 or 346-8228; or check their web site at: www.medicalassurance.com

WVSMA, WV Public Health Association awarded CAHP grant

Cooperative Actions for Health Program has awarded $15,000 to the WVSMA and WV Public Health Association, in cooperation with the WV Bureau for Public Health.

The purpose of this grant award is to build, support, and strengthen collaboration between medical and public health professionals to improve the health of the citizens of West Virginia. The grant period is from Oct. 1, 1998 to Sept. 30, 1999.

Advising this project is the Continuing Education Committee of the WV Public Health Association, chaired by Dr. Alan Ducatman of the WVU School of Medicine. The WVSMA representative is Tim Allman, and the WV Osteopathic Association will also have a representative.

For more details, phone 558-0051.

Preliminary Program

Thursday, January 21

9 a.m. - Noon	Coding and Billing Seminar
1 p.m. -3 p.m.	Medical Assurance Loss Prevention Seminar
6:30 p.m. - 8 p.m.	**Legislative Reception**
8 p.m.	WVSMA Executive Committee Business Meeting

Friday, January 22

7 a.m.	WVSMA Committee on Medical Education
8 a.m. - 1 p.m.	WVMI Scientific Meeting
8:30 a.m. - 11 a.m.	*"Looking Ahead in CME: Plotting a Course for the Future"*
11 a.m. - 5 p.m.	WVSMA Registration
Noon	Publication Meeting
Noon - 2 p.m.	Local Health Officer's Luncheon, Hosted by the Bureau of Public Health
1 p.m. - 4:30 p.m.	Exhibit Visitation
1 p.m. -5 p.m.	**FIRST SCIENTIFIC SESSION** *"Impotence"* Stan Kanzari, MD *"Overview of Viral Hepatitis A-G"* Fredric G. Regenstein, MD *"Title of be Announced"* Even Alexander, III, MD *"Abnormal Pap Smear"* Paul H. Fulcher, MD
3:30 p.m.	WVSMA Scientific & Education Sessions Committee Meeting
4:30 p.m. - 5:30 p.m.	Marshall University Alumni Board of Directors Meeting
5:30 p.m. - 7 p.m.	Reception, co-hosted by West Virginia University and Marshall University Schools of Medicine
7 p.m.	**PHYSICIAN SESSION/PUBLIC SESSION** ***"Violence in the Streets Becomes Violence in the Home"*** Cindy W. Christian, MD, assistant professor of pediatrics at the Children's Hospital of Philadelphia and University of Pennsylvania School of Medicine, Sgt. Tom Westfall, Marshall County Sheriff's Department and Jerome D. Massenburg, MD, Charleston Psychiatric Group

Saturday, January 23

7:30 a.m. - 8:30 a.m.	WVSMA Surgery Section Breakfast Meeting
8:30 a.m. - 4:30 p.m.	Exhibit Visitation/Registration
8:30 a.m. - 4 p.m.	WVSMA Medical Student Section Meeting and Luncheon
9 a.m. - Noon	**SECOND SCIENTIFIC SESSION, "Controversies in Medicine"** ***"Antibiotic Treatment of Acute Pediatric Otitis Media"*** *"Controversies in Management of Acute Otitis Media"* Robert E. Polland, MD *"Toward Judicious Use of Antibiotics in Management of Otitis Media"* Kenneth M. Grundfast, MD, FACS, FAAP **"Alternative Medicine"** *"It Doesn't Have to be Either Or"* Tara Sharma, MD
11 a.m. -2 p.m.	WV Urological Society Meeting
Noon - 4 p.m.	WV Psychiatric Association
Noon	**Specialty Luncheon Meetings**, *various chapters of West Virginia Specialty Societies will be scheduled for luncheon/business and scientific meetings. Times and locations will be noted at a later date in the West Virginia Medical Journal and the official program.*
Noon - 1:30 p.m.	**Lunch & Learn** - ***"Affects of Abuse on Families, Particularly Children"*** Daniel S. Foster, MD, Moderator, Cindy W. Christian, MD, Linda Cooper, RN, MSN, Additional panelist TBA
Noon - 2 p.m.	WV State Society of Anesthesiologists
1:30 p.m. - 5 p.m.	**THIRD SCIENTIFIC SESSION , "End-of-Life Care"** *"Palliative Care: A Moral Mandate for All Physicians"* Alvin H. Moss, MD *"When is a Patient Dying: What Does the Medical Literature Say?"* Sue Warren, MD, FACP *"Patient-Centered Pain Management at the End-of-Life"* Timothy Deer, MD, DABPM, FAADEP *"The Ethics of Eating, Feeding, and Sedating at the End-of-Life"* Jacqueline J. Glover, PhD **Panel Presentation and Panel Discussion** - *"Dilaudid Did Not Touch Her Pain"*
7:30 p.m.	Entertainment - Comedian/Attorney, Bob Noone, followed by Dr. Rano Bofill Hosted by Acordia of WV and Medical Assurance of WV

Sunday, January 24

7 a.m.	WVSMA Council Breakfast Meeting
8:30 a.m. - Noon	Exhibit Visitation/Registration
9 a.m. - Noon	**FOURTH SCIENTIFIC SESSION, "Potpourri of Topics"** *"Image Guided Breast Biospies"* Margaret Kemeny, MD *"The Practical Use of Guidelines in Improving the Care of Patients With Low Back Pain in a Large Hospital System"* Mark Stephens, MD and Marsha Bailey, MD *"Stump the Audience"* Robert J. Marshall,MD, Warren Point, MD, Moderators and distinguished guests, James E. Brick, MD, James Gregory Rosencrance, MD, and Kevin W. Yingling, MD

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Mid-Winter Clinical Conference

WV State Medical Association

Embassy Suites, Charleston, WV

January 21-24, 1999

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❒ WVSMA Member $115 ❒ Non-Member $165

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❒ WVSMA Member $125 ❒ Non-Member $175

Lunch & Learn – Saturday, Jan. 23, 1999

"Affects of Abuse on Families, Particulary Children," Cindy W. Christian, MD

❒ Physicians $50 ❒ All others $35

All room reservations at the Embassy Suites MUST be made by Dec. 28 to receive a special group rate, call (304) 347-8700

Don't Wait...Register NOW to

Lunch & Learn

Join us at the Embassy Suites during our 1999 Mid-Winter Clinical Conference for our popular Lunch & Learn program, Saturday, Jan. 23 at noon. This year's topic will be *"Affects of Abuse on Families, Particularly Children."*
Speakers include:

Cindy W. Christian, M.D.,
assistant professor of pediatrics at the
Children's Hospital of Philadelphia.

Linda Cooper, R.N., M.S.N.,
director of the Family Resource Center at
Women and Children's Hospital in Charleston.

Additional panelist TBA

The cost for physicians is $50 and $35 for all others. 1.5 CME credits will be offered for the Lunch & Learn program.

Space is limited, so it is important to register NOW if you plan to attend this informative session.
To register, please call the WVSMA at (304) 925-0342 or (800) 257-4747 or visit the WVSMA Registration Desk during the Mid-Winter Clinical Conference.

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Plan to attend a wildly entertaining evening of parody, comedy, and singing during the 1999 West Virginia State Medical Association Mid-Winter Clinical Conference at the Embassy Suites in Charleston.

Acordia of WV and Medical Assurance of WV will host Bob Noone, a.k.a. "The Perry Mason of Parody," Saturday, January 23 at 8:30 p.m. at the Embassy Suites.

Following Bob's performance, Dr. Rano Bofill will delight the crowd with his famous laser karoke show and numerous dance contests!

Both Bob and Dr. Bofill said they are looking forward to entertaining physicians from around the state!

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"Aftermath of the MIDCAB Procedure"
Jan. 6, 12:30 p.m., Ozuru O. Okuha, M.D., Montgomery General Hospital, Montgomery

"New Guidelines for Head and Spine Health Issues"
Jan. 8, noon, Sherry Apple, M.D., Logan General Hospital, Logan

"Update in the Treatment of Asthma"
Jan. 12, noon, B. Nassiri, M.D., Plateau Medical Center, Oak Hill

"Forensic Evidence in the Emergency Department"
Jan. 18, 5:45 p.m., Michael King, Jackson County Regional Outreach, Sycamore Country Club, Ripley

"Update on Alzheimer's Disease"
Jan. 19, 6:30 p.m., James Griffith, M.D., Roane General Hospital, Spencer

"Medical Treatment of Pneumonia"
Jan. 20, 6 p.m., Alfred Pfister, M.D., Man APH, Man

"Type II Diabetes: A Primary Care Approach"
(Seminar Jan. 27, 12:30 p.m. - 5 p.m.), Charleston Civic Center, Charleston

"Cardiology Conference at Snowshoe"
(With the American College of Cardiology) Feb. 2-4, Mountain Lodge Conference Center, Snowshoe

"Chemical Hazards in the Kanawha Valley"
Feb. 3, 12:30 p.m., Bipin Avashia, M.D., Montgomery General Hospital, Montgomery

Huntington Community Medical Foundation

"Network 2000 Trauma Conference"
(Joint Sponsorship with Paul B. Hall Regional Medical Center and HealthNet III), Jan. 9, 7:45 a.m. - 1:30 p.m., Ramada Inn (formerly the Carriage House), Paintsville

"Assessment and Treatment of the Rural Trauma Patient" - Harry Brizendine, M.D.
"Cervical and Spinal Trauma" - David Weinsweig, M.D.
"Assessment and Treatment of the Rural Trauma Patient" - David Chaffin Jr., M.D.
"Thoracic Trauma" - Jeff George, M.D.
"Assessmentand Treatment of the Pediatric Trauma Patient - Michael Waldeck, M.D.
"Trauma Stabilization and Transfer" - David Denning, M.D.

Marshall University School of Medicine

"Research Days"
March 29-30

Robert C. Byrd HSC - Morgantown

"Preparatory Course for Urology Certifying Exam"
Jan. 14-16, Embassy Suites, Pittsburgh

"Conference on Rural Health Services"
March 17, Robert C. Byrd HSC of WVU, Morgantown

"Sixth Annual Stephen C. Rector Visiting Lectureship in Emergency Medicine"
April 22, Robert C. Byrd HSC of WVU, Morgantown

"The Edward H. Stullken, Jr. Lectureship: Trends in Managed Care"
April (Tenative), Robert C. Byrd HSC, Morgantown

"STD/AIDS in West Virginia '99"
May 6-8, Embassy Suites, Charleston

"Virginia and West Virginia Societies of Anesthesiology Annual Meeting"
May 28-30, The Greenbrier, White Sulphur Springs

"Advanced Life Support in Obstetrics"
July 23-25, Canaan Valley Resort, Davis

"25th Annual Hal Wanger Family Medicine Conference"
Robert C. Byrd HSC of WVU, Morgantown

West Virginia State Medical Association

WVSMA's Mid-Winter Clinical Conference"
Jan. 21-24, Embassy Suites, Charleston

WVSMA's Annual Meeting
Aug. 25-28, The Greenbrier, White Sulphur Springs

Unintended Pregnancy in West Virginia

Unintended pregnancy is both frequent and widespread in West Virginia, as well as in the United States. Unintended pregnancy is not just a problem of adolescents, unmarried women, poor women or minorities; it affects all segments of our society.

The U.S. has among the highest rates of unintended pregnancy and teenage pregnancy found in Western nations, despite the availability of effective contraceptive methods. Contraceptive use and unintended pregnancy are influenced by multiple factors: knowledge about contraceptive methods and reproductive health, individual skill in using contraception properly, personal feelings and attitudes, sexual behaviors, access to contraceptive methods, cultural and religious values, sexual saturation of the media, and others as well. The number and complexity of these factors mean that no single or simple intervention is likely to solve the problem of unintended pregnancy (1).

In the U.S., nine in 10 women who are sexually active, fertile, and do not wish to become pregnant, report that they use a contraceptive method. Yet, nearly 60% of the six million pregnancies (the total number of births, abortions and miscarriages) in the U.S. annually are unintended, either mistimed or unwanted altogether. Among teenagers, eight in 10 pregnancies are often unintended (2).

Each year in WV, 78 pregnancies occur per 1,000 women ages 15-44, and 70% of these pregnancies result in live births and 14% in abortions. The state's teen pregnancy rate ranks 36th nationally. There are 85 pregnancies annually per 1,000 teens ages 15-19 in WV; 66% result in live births and 19% result in abortions (3).

WV is one of 16 states participating in the Pregnancy Risk Assessment Monitoring System project (PRAMS). PRAMS is a population-based survey of WV women who have recently delivered live births. PRAMS data indicates that between 1991 and 1995, there was a rise in the proportion of unintended pregnancies in the state. In 1991, 40.77% of all pregnancies were unintended; in 1995, that figure increased to 45.21% (4).

PRAMS data also indicates that women experiencing unintended pregnancies are less likely to receive first trimester prenatal care, increasing the likelihood of a poor pregnancy outcome; more likely to have the prenatal care paid for by Medicaid; more likely to be an adolescent (age 19 and under); and more likely to have only or less than a high school education (5).

Investments in reproductive health services represent a cost-effective utilization of limited public resources. Every dollar spent for contraceptive services saves $3 in public funds that would have been needed to provide prenatal and newborn medical care alone (6).

By allowing individuals to make choices regarding the spacing and number of their children and increasing the interval between births, family planning plays an integral role in efforts to reduce infant morbidity and mortality, as well as to improve women's health. The American College of Obstetricians and Gynecologists recommends birth spacing of two years as the desired interval between pregnancies.

The WV Family Planning Program provides reproductive health care for low-income women, men and adolescents by providing clinical services, education and contraceptive supplies to prevent unintended pregnancies. In WV, 116,190 women ages 13-44 — including 36,300 teenagers — are in need of publically-supported contraceptive services. WV ranks second nationally in the provision of contraceptive services to women in need. While 128 publically-supported Family Planning Program clinics in WV serve almost 74,000 women and teens, this represents only 63% of all women in need and 67% of teenagers in need (7).

A primary goal of the Family Planning Program is to promote *planning* for pregnancy, as much as *avoiding* an unintended pregnancy. Activities to reach this goal include the availability of increased federal, state and local public funding for comprehensive contraceptive services, especially those for low-income women and adolescents who face major financial barriers in securing such care; increasing access to contraception; and improving knowledge about contraception, unintended pregnancy, preconception and reproductive health.

In 1995, the Institute of Medicine's Committee on Unintended Pregnancy urged that the nation adopt a new social norm: *All pregnancies should be intended — that is, they should be consciously and clearly intended at the time of conception* (8).

For more details about the Family Planning Program or the references in this article, contact 1-800-642-8522.

Anne Williams, Denise Smith and
Patty Pearson
Office of Maternal and Child Health
Bureau for Public Health

Poetry Corner

A Kid in a Chair

As I am in this chair,
I think that it is not fair.
Why can't I get up and run
and have some fun.
All the other kids are playing,
swinging around and swaying.
Oh, how I long to get up,
run around and play with my pup.
But my legs, they do not work.
Other kids point, laugh and smirk,
as I sit in this chair,
this damn chair it's so unfair.
It's not my fault, I was born this way.
Is what I think of every day.
My hands are so sore,
I can't take it anymore.
Wheeling myself around,
trying not to frown.
I want to get out of this chair.
This damn chair, it's so unfair.

-- Anonymous

Robert C. Byrd Health Sciences Center of West Virginia University News

WVUH admission standard adjusted

Halbritter

The standard of practice at WVU Hospitals has been changed to accept all patients, without delay, upon the request of a community physician.

The change was made to make the referral process easier for West Virginia physicians, said Dr. Kevin Halbritter, recently appointed vice president for medical staff affairs at WVUH. "We're making WVU's Medical Access and Referral System (MARS) a one-call access point for physicians who wish to transfer a patient to WVUH," he said. "The MARS operator can collect demographic and other data about a patient, page a faculty physician, and assure that the referral process won't take a great deal of the physician's time, or office staff time."

WVU also recently adopted new patient care and referring physician standards for faculty physicians, medical residents, and students. The standards require WVU faculty physicians to:

- communicate with each patient's primary physician at each major event in the patient's care, including diagnosis, hospital admission, surgery or discharge.
- consult with the referring physician prior to transfer to another specialist.
- send the patient back to the referring physician.
- respond promptly to calls from referring physicians and patients.
- refrain from negative comments about referring physicians and the care they provide.

Physicians with questions should contact Dr. Halbritter at the MARS office at 1-800-WVA-MARS or (304) 598-6000.

Distinguished Medical Alumnus for 1998 receives honors, lectures

Beckley native Dr. Margaret "Anne" Kessinger, who is the WVU School of Medicine's 1998 Distinguished Alumnus, visited WVU recently for a weekend of honors and lectures.

Dr. Kessinger, a pioneer in blood and marrow transplantation, is a professor of medicine at the University of Nebraska Medical Center and chief of the Center's oncology/hematology section. She received her medical degree from WVU in 1967.

New Halstead Society president

Dr. Gordon F. Murray, chair of the Department of Surgery, poses with the presidential gavel of the Halstead Society in front of a painting of Dr. Bernard Zimmerman, who served as Halstead Society president in 1972, during his tenure as chair of WVU's Surgery Department. Dr. Murray was elected president of the Halstead Society at the group's meeting at the University of Florida in Jacksonville. The Halstead Society is named after Dr. William Stewart Halstead, who is credited with developing a basic scientific approach to surgery.

Epilepsy surgery now available

Brick

Patients who have epilepsy that is resistant to control by medication may be candidates for curative surgery now available at WVU.

"Some patients can be on medication for decades and still not be free of the effects of epilepsy," said Dr. John Brick. "Temporal lobectomy, in carefully chosen patients, may offer a 65 to 70 percent chance of a life without seizures. We believe there are 300 to 400 people in West Virginia who could benefit from this operation."

A team of physicians, surgeons, psychologists, nurses and technicians evaluates each candidate for surgery, and the point of origin of the seizures is determined with MRI, EEG and PET. The surgery is performed on patients from the early teen years on.

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Marshall University School of Medicine News

Children with special needs benefiting from new partnership

To expand and coordinate services for children with disabilities, the Marshall University School of Medicine and Prestera Center have formed a new partnership. Under the umbrella of Helping Hands Development Center, founded by University Pediatrics in 1995, the partners will help families manage issues associated with a wide range of needs, from attention deficit disorder to celebral palsy, muscular dystrophy, neurologic problems, and traumatic head injury.

"People are sometimes surprised to learn that of the more than 900 new patients we add every year at Helping Hands, the No. 1 reason for referral is ADHD (attention deficit hyperactivity disorder), behavioral issues and school problems," said Dr. Thomas Rugino, the center's medical director. "While we have some children who have strictly musculoskeletal problems,the overwhelming majority of our patients are dealing with behavioral issues or developmental disabilities of some kind. By joining forces with Prestera, we will be able to meet those children's needs more effectively while making the process much simpler for families."

Maurice Cooley, director of development for the Prestera Center, said Marshall's physician specialists will continue to provide a full range of medical services and Prestera will provide psychological assessments, psychiatric evaluations, and specialized outpatient treatment for complex psychological and behavioral problems. In addition, Prestera will provide case management services.

"Each family will work with a family coordinator who may, when clinically indicated, work with families and physicians to develop a targeted treatment plan and coordinate the delivery of services with other partnership participants, such as Developmental Therapy Center, Autism Services Center and the Autism Training Center," said Cooley. "By providing a single point of entry to a wide range of services, we will be able to greatly simplify the process for families. To better meet the needs of our youth, we intend to have a strong working relationship with our local schools."

Rugino said the center's goal is to provide family-centered care that allows children with special health and developmental needs to participate at the highest possible level within their families and communities. But reaching such a goal takes a lot of teamwork, Rugino and Cooley said.

Helping Hands is located in the Marshall University Medical Center. For additional information or to make a referral, call (304) 691-1302.

Stover to assume leadership of UP & S

Gerry D. Stover of Hurricane has been named chief executive officer of University Physicians & Surgeons effective January 1.

Stover has served as executive vice president of the WV Academy of Family Physicians since 1997. Previously, he was executive director of the Lincoln Primary Care Center, a position he held from 1986 to 1996. He was the clinic administrator for the West Virginia Air National Guard in Charleston from 1986 to 1998, and currently is a lieutenant colonel in the Air Force Reserve.

A 1977 graduate of Marshall University, Stover has been associated with the School of Medicine since 1984, when he became assistant administrator for business affairs for John Marshall Medical Services, which later was renamed UP&S. He has been a clinical assistant professor of family and community health since 1985.

He served as chairman of the Governor's Process Action Team on Health Care Reform, and has been a governor's appointee to the Rural Health Advisory Panel, the Partnership for Progress Task Force, and the Medicaid Crisis Panel. He served as president of the board and CEO of the Statewide Health Information Network, and has been vice president of the West Virginia Primary Care Study Group.

MU ranks nationally in number of grads entering pediatrics

Marshall ranks third in the nation in the percentage of graduates entering pediatrics residencies, according to Pediatric News.

Based on data from the American Medical Student Association, 14 percent of Marshall medical students graduating in 1977 entered pediatrics training. The only schools with higher percentages were the University of South Carolina (14.6%) and University of Illinois, Urbana-Champaign (14.4%).

"It's not unexpected, yet gratifying, that in another primary care specialty Marshall is among the nation's leaders," said Dr. Patrick I. Brown, associate dean for academic and clinical affairs.

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December, 1998

MAMSI Announces New Medical Director

MAMSI is pleased to welcome **Thomas S. Lanava, M.D.** as our new Medical Director for West Virginia. Tom shares our company's view that physician involvement and leadership are essential as the health care system evolves. You can reach him at our full-service Medical Affairs Department - **(800) 797-2352.** We're committed to quality and service - to our members and to you. Call us whenever we can help you.

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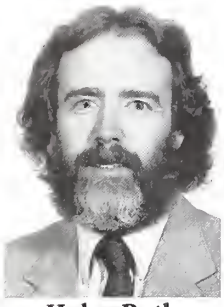
West Virginia School of Osteopathic Medicine News

Three faculty promoted; four granted tenure

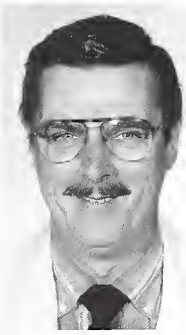

Hyler-Both

Nemitz

Schriefer

Hupka

Lemley


Small

Wallace

Seven faculty members from the West Virginia School of Osteopathic Medicine were recently granted tenure or promoted to full professor, according to James Stookey, D.O., vice president for academic affairs and dean of students.

David Hyler-Both, D.O., was promoted to professor of family practice and osteopathic manipulative medicine; James Nemitz, Ph.D., director of physician underserved and rural retention, was promoted to professor of anatomy; and John Schriefer, Ph.D., was promoted to professor of pharmacology.

The faculty members who were granted tenure included Aurthur Hupka, Ph.D., professor of pharmacology; William Lemley, D.O.; associate professor of family practice; and Gregory Wallace, D.O., associate professor of pediatrics.

Grant to benefit instruction at WVSOM

WVSOM officials are excited about a recent grant from the Department of Health and Human Services that will help its Family Medicine faculty use new computer-based learning resources to improve instruction.

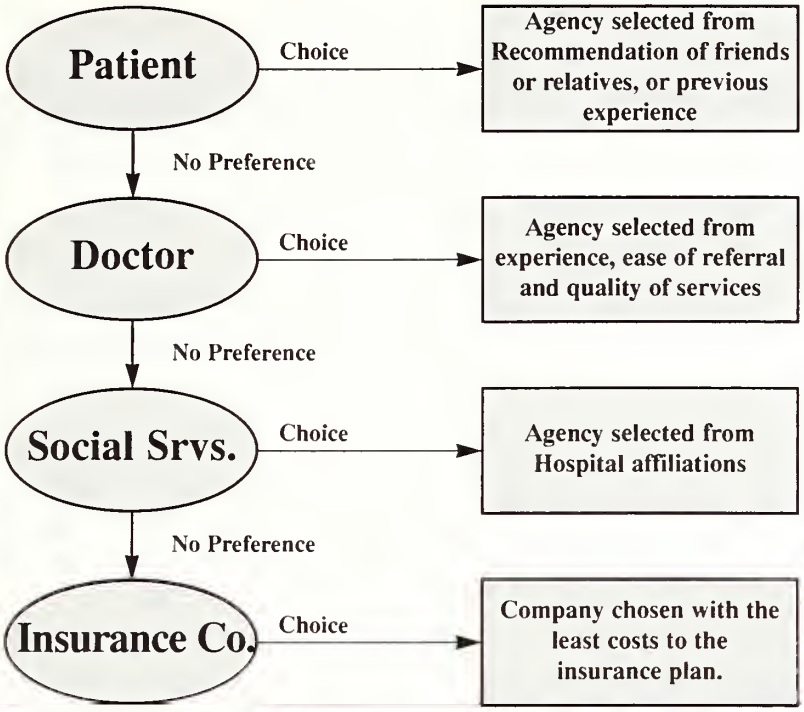
"Osteopathic medicine has traditionally emphasized primary care and service to smaller communities. In part, WVSOM's success in receiving this grant resulted from this tradition, and specifically WVSOM's success in graduating family practice physicians," explained Helen Baker, Ph.D., director of educational development and professor of family medicine.

"Thirty-seven members of WVSOM's 1996 graduating class of 63 are enrolled in family medicine residency programs, or 57 percent. That's one of the highest in the nation," Dr. Baker pointed out, adding that WVSOM's average family medicine residency enrollment of 45 percent over the years of 1993-1996 far exceeds the national average.

Craig Boisvert, D.O., who is the project director, believes the funds will provide WVSOM professors with resources and training which will allow them to better educate students and prepare them for careers in primary care.

"Technology often races along so fast that it threatens to leave many in its wake," said Dr. Boisvert. "This grant will asssist WVSOM Family Medicine faculty in keeping up with the latest technology, especially helping in the development of learning materials for presentations to our students," he added.

Healthcare — Who's Choice is it?



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Take every opportunity to increase membership

A new face stood out in the crowd of exercisers. Sporting my "Welcome-to-Beckley" smile, I realized that this new woman, Mary Ann, I was talking to was a physician's spouse. Her familiar name was on my list of potential Alliance members, prepared by the efficient staff of the medical society.

While we were working out on the treadmill, I mentioned that we have a medical alliance that promotes and supports medical families and the family of medicine.

"Why should I join?" was the question that echoed in my ears. As fast as I could while walking on the treadmill I said, "Do you know that it feels good to belong to a group who promotes the well-being of people not only in our area, but everywhere?"

I continued by telling her that the AMA Alliance has a successful nationwide promotion called SAVE (Stop America's Violence Everywhere), now going on its fourth year.

I told her that in our community, thousands of students and residents have benefited from our programs on prevention of domestic violence and date rape, the media's negative effects on children, the importance of creating a smoke-free environment, and breast cancer awareness.

"At Alliance monthly meetings, we meet friends and listen to programs of interest to us and our family members. You can even join the fitness program or share your talents and assistance," I told her.

As I finished my last sentence, she muttered, "But I don't have time to attend meetings."

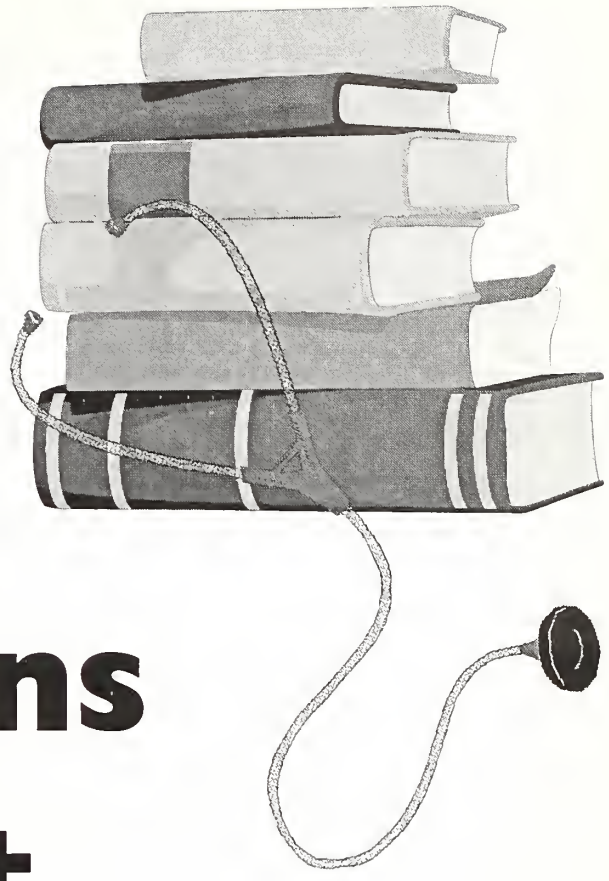
I continued with encouraging remarks, "I know that most of us are busy and we can't be actively involved; however, your membership dues support health and work-related legislative initiatives that influence physicians. Your financial support also helps with medical research and the education of medical students through the AMA Foundation. Membership is vital to the success of the Alliance because when you join the state and national Alliance, as well as your local chapter, we as a whole add a very powerful voice in health, research and legislative concerns."

Mary Ann nodded and smiled. I paused from my persistent marketing, thanked Mary Ann and told her I would like to take her as my guest to the next Alliance meeting. Not only had I had a great workout that day, I had hopefully gained a new friend and a new member for the Alliance.

Before I left, I quickly quipped with a merry wink in my eye, "And Mary Ann, don't forget to tell your husband to ask his colleagues to let their spouses join the Alliance too, if they haven't yet."

Rose Romero
President-Elect, WVSMA Alliance

From one generation of physicians to the next.



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- **Mail checks to Michelle Latos, 2 Augustwood, Wheeling, WV 26003. For information about AMA Foundation, call (304) 233-7480**

New Members

We are pleased to welcome the following new members to the WVSMA:

Physicians

Jennifer Momen, MD
Bridgeport, WV

Frederick Martinez, MD
Huntington, WV

Peter Filozof, MD
Parkersburg, WV

James P. Wagner, DO
Pt. Pleasant, WV

Daniel J. McGraw, MD
Parkersburg, WV

Stephen H. Goldberger, MD
Bluefield, WV

Glenn F. Elliott, DO
Wheeling, WV

A. Jane Maloof, MD
Beckley, WV

Eric Persily, MD
Charleston, WV

Charles D. Francis, MD
Charleston, WV

Syed Rasheed, MD
Beckley, WV

Bruce N. Edwards, MD
Hagerstown, MD

Robert Steinberger, MD
Kingwood, WV

Michael D. Roberts, MD
Parkersburg, WV

Residents

Rafael A. Cott, Jr., MD
Wheeling, WV

Muhammad Akhtar, MD
Wheeling, WV

Nesreen A. BenHamed, MD
Huntington, WV

Medical Students

Marshall University School of Medicine:

Robert Harmon
Steven C. Lochow
Kevin M. Milam
Amy E. Mortensen
Scott E. Maynard
Tarun M. Kumar
Pradipta Ghosh
Christine Jones
Lana J. Davenport
Christopher S. Goode
Leslie M. Kidd-Rotter
Douglas F. Ritchie
Amanda E. Bennett
Autumn B. Whitlock
Heather M. Skeens
Haleh Heydarian
Kerri G. Donahue
Staci A. Kerr
Wallace K. Ammon
Stephen S. King

WVU School of Medicine (Charleston Campus):

Amy L. Lipscomb

WVU School of Medicine (Morgantown Campus):

Kenneth K. Jones
Serrhel G. Adams, Jr.
John L. Morris
Victoria C. Chans
Robby Keith
Christopher Nair
Stephanie Kirby
Thomas Horsman
Janel Freed
Nick Abedi
Eric Adkins
William McBee
Scott Bailey
Robert Johnston
Jason Gunn
Jason Given
Cyrus Kavasmaneck
Matthew Hofeldt
Hormuz Wadia
Christofaro R. Larzo
Bandy B. Mullins
Melissa A. Jugo
Matthew J. Wilson
Sujoy Gill
Corey VanHoff
David Massinople
Sharon Cabotaje
Olivia Ostrow
Hrishi Kanth
Michelle Paulson
Tracy Ting

West Virginia School of Osteopathic Medicine:

Mark S. Bowers
Robert Olexo
Karyn Molinari

Aaron Kendrick
Tamara McVay
Leslee Hudgias
Dan Breece
Jennifer Dowdy
David Prisk
Dona Leskuski
William Bohannon
Jessica Benson
William Zimmerman
Francis Demuth, Jr.
James Campbell
Johnna Jackson
Eddie Anderson
Kimberly Ballard
Michael Collins
Jason Shepherd
Ronald Billips
Stephen Fryer, II
Brandi Alt
Christina Reinbold
April English
Heather Straight
Heidi Ross
Deborah Franklin

- All new members will receive new members packets within the next few weeks!

- We would like to invite our new members to attend the WVSMA's 1999 Mid-Winter Clinical Conference which will take place from January 21-24 at the Embassy Suites in Charleston. Please turn to the General News Section and also to pages 336-340 for more information about this meeting. In addition, we invite our new medical student members to attend the WVSMA Medical Student Section's Annual Meeting which will be conducted during the Mid-Winter conference. Please see page 351 for more details about this event.

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1998 Index of Scientific Authors

ABORAYA, Ahmed F., M.D., Dr.P.H.; Allen Tien, M.D., M.S.; James Stevenson, M.D.; Kerr Crosby — *Schedules for Clinical Assessment in Neuropsychiatry (SCAN): Introduction to WV's mental health community* Nov/Dec 326

ALBARRACIN, Cesar, M.D.; Gregory Rosencrance, M.D.; James Boland, M.D.; Jaime E. Hernandez, M.D. — *Bacteremia due to streptococcus zooepidemicus associated with an abdominal aortic aneurysm* Mar/Apr 90

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BRAGER, Paul M., M.D.; Chinmay K. Datta, M.D., Ph.D.; James D. Weinstein, M.D.; James E. Bland, M.D.; Michael A. Stewart, M.D. — *A case of cervical lymph node metastasis resulting from glioblastoma multiforme* Sept/Oct 276

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Annual Audit 1997

The annual audit of the West Virginia State Medical Association for the calendar year 1997 has been completed by Ernst and Young LLP of Charleston. The complete audited financial statements including the report of independent auditors is as follows:

REPORT OF INDEPENDENT AUDITORS

To the Council
West Virginia State Medical Association

We have audited the accompanying statements of financial position of West Virginia State Medical Association (WVSMA) as of December 31, 1997 and 1996, and the related statements of activities and cash flows for the years then ended. These financial statements are the responsibility of WVSMA's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of WVSMA as of December 31, 1997 and 1996, and the changes in its net assets and its cash flows for the years then ended in conformity with generally accepted accounting principles.

Ernst and Young LLP

May 29, 1998

STATEMENTS OF FINANCIAL POSITION

	December 31 1997	1996
Assets		
Cash and cash equivalents	$ 665,487	$ 779,106
Accounts receivable, less allowance for doubtful accounts of $11,000	22,350	16,680
Other assets	19,108	13,427
Land, building, and equipment, net	565,487	582,016
Long-term investments-restricted	48,400	44,200
Total assets	$1,320,832	$1,435,429
Liabilities and net assets		
Liabilities:		
Dues collected in advance	$ 572,889	$ 582,685
Accounts payable	5,673	10,719
Accrued expenses and other liabilities	48,233	52,243
Note payable to bank	327,653	367,296
Total liabilities	954,448	1,012,943
Net assets:		
Unrestricted	318,809	379,751
Temporarily restricted	43,325	38,485
Permanently restricted	4,250	4,250
Total net assets	366,384	422,486
Total liabilities and net assets	$1,320,832	$1,435,429

See notes to financial statements.

Statements of Activities

	Year Ended December 31, 1997			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Revenues and other support				
Dues	$ 730,807	$ –	$ –	$ 730,807
Royalty endorsements	176,979	–	–	176,979
Advertising	23,062	–	–	23,062
Conferences and meetings	67,005	–	–	67,005
Investment income	23,555	1,552	–	25,107
Other income	27,107	–	–	27,107
Unrealized net gain on investments	–	4,200	–	4,200
	1,048,515	5,752	–	1,054,267
Net assets released from restrictions	912	(912)	–	–
Total revenues and reclassifications	1,049,427	4,840	–	1,054,267
Expenses				
Membership services	180,270	–	–	180,270
Conferences and meetings	293,470	–	–	293,470
Legislative	123,529	–	–	123,529
The West Virginia Medical Journal	140,115	–	–	140,115
Management and general	324,822	–	–	324,822
Professional liability	48,163	–	–	48,163
Total expenses	1,110,369	–	–	1,110,369
Change in net assets	(60,942)	4,840	–	(56,102)
Net assets at beginning of year	379,751	38,485	4,250	422,486
Net assets at end of year	$ 318,809	$43,325	$4,250	$366,384

See notes to financial statements.

Statements of Activities (continued)

	Year Ended December 31, 1996			
	Unrestricted	Temporarily Restricted	Permanently Restricted	Total
Revenues and other support				
Dues	$ 749,995	$ -	$ -	$ 749,995
Royalty endorsements	173,399	-	-	173,399
Advertising	25,813	-	-	25,813
Conferences and meetings	74,766	-	-	74,766
Investment income	27,313	1,552	-	28,865
Other income	17,683	-	-	17,683
Unrealized net gain on investments	-	25,800	-	25,800
	1,068,969	27,352	-	1,096,321
Net assets released from restrictions	1,175	(1,175)	-	-
Total revenues and reclassifications	1,070,144	26,177	-	1,096,321
Expenses				
Membership services	170,849	-	-	170,849
Conferences and meetings	295,049	-	-	295,049
Legislative	116,471	-	-	116,471
The West Virginia Medical Journal	143,522	-	-	143,522
Management and general	335,321	-	-	335,321
Professional liability	53,038	-	-	53,038
Total expenses	1,114,250	-	-	1,114,250
Change in net assets	(44,106)	26,177	-	(17,929)
Net assets at beginning of year	423,857	12,308	4,250	440,415
Net assets at end of year	$ 379,751	$38,485	$4,250	$ 422,486

See notes to financial statements.

Statements of Cash Flows

	Year Ended December 31 1997	1996
Operating activities		
Change in net assets	$ (56,102)	$ (17,929)
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Unrealized net gain on investments	(4,200)	(25,800)
Depreciation	28,627	27,939
Changes in operating assets and liabilities:		
(Increase) in accounts receivable	(5,670)	(2,697)
(Increase) decrease in other assets	(5,681)	3,335
(Decrease) in dues collected in advance	(9,796)	(95,319)
(Decrease) increase in accounts payable	(5,046)	8,556
(Decrease) increase in accrued expenses and other liabilities	(4,010)	13,974
Net cash used in operating activities	(61,878)	(87,941)
Investing activities		
Purchases of equipment	(12,098)	(16,244)
Net cash used in investing activities	(12,098)	(16,244)
Financing activities		
Repayment of note payable to bank	(39,643)	(41,059)
Net cash used in financing activities	(39,643)	(41,059)
Decrease in cash and cash equivalents	(113,619)	(145,244)
Cash and cash equivalents at beginning of year	779,106	924,350
Cash and cash equivalents at end of year	$665,487	$779,106

See notes to financial statements.

Notes to Financial Statements
December 31, 1997

1. Description of Organization and Summary of Significant Accounting Policies

WVSMA is a nonprofit corporation organized under the laws of the State of West Virginia and exempt from income tax under Section 501(c)(6) of the Internal Revenue Code. WVSMA functions primarily to inform its members about proposed legislation, current professional developments, professional risk and malpractice liabilities, and also publishes the *West Virginia Medical Journal*. Substantially all of WVSMA's revenues are generated by dues assessments on its members and royalty endorsements.

Basis of Presentation

WVSMA has adopted Statement of Financial Accounting Standards (SFAS) No. 116, *Accounting for Contributions Received and Contributions Made*, SFAS No. 117, *Financial Statements of Not-for-Profit Organizations*, and SFAS No. 124, *Accounting for Certain Investments Held by Not-for-Profit Organizations*. SFAS No. 116 establishes standards of accounting for contributions and requires that unconditional promises to give be recognized as revenue in the period received at their fair value. SFAS No. 117 requires that resources be classified for reporting purposes into three net asset categories as temporarily restricted, permanently restricted and unrestricted net assets according to the existence or absence of donor-imposed restrictions. Temporarily restricted net assets are those whose use has been limited by donors to a specific purpose or time period. Donor restricted contributions whose restrictions are met in the same reporting period are reported as unrestricted support. Permanently restricted net assets are those for which donors require the principal of the gift to be maintained in perpetuity. SFAS No. 124 requires not-for-profit organizations to record their investments in all debt securities and certain equity securities at fair value, with gains and losses (realized and unrealized) being recorded in the statement of activities and changes in net assets.

Use of Estimates

The preparation of the financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect amounts reported in the financial statements and accompanying notes. Such estimates and assumptions could change in the future as more information becomes known which could impact the amount reported and disclosed herein.

Cash and Cash Equivalents

Cash and cash equivalents are comprised of short-term certificates of deposit and money market accounts recorded at cost which approximates market. Bank balances as of December 31, 1997 and 1996, approximated $728,000 and $837,000, of which approximately $119,000 and $114,000, respectively, was covered by federal depository insurance. The remaining balance is unsecured.

Allowance for Doubtful Accounts

WVSMA values its accounts receivable at net realizable value by expensing amounts determined to be uncollectible in the period of determination.

Land, Building, and Equipment

Land, building, and equipment are recorded at historical cost. Depreciation is computed by the straight-line method using estimated useful lives ranging from 5 to 35 years. The cost of maintenance and repairs is charged to income as incurred and significant improvements are capitalized.

Recognition of Revenue

Members are billed in advance for the subsequent years dues, which are treated as exchange transactions and earned ratably over the period to which they relate. All subsequent years dues received prior to January 1 are reported as dues collected in advance.

Long-Term Investments

Long-term investments consist of equity investments in a permanently restricted endowment fund, which was established to utilize the dividend income to pay for the guest speaker at the annual meeting. These securities are recorded at fair value based on quoted market prices.

Temporarily Restricted Net Assets

Dividend income and realized and unrealized gains/losses on the permanently restricted endowment fund equity securities restricted for the costs of the guest speaker at the annual meeting are reported as temporarily restricted revenue when received. When the donor restriction expires, that is, when the stipulated purpose restriction is accomplished, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of activities as net assets released from restrictions.

Permanently Restricted Net Assets

These net assets, with an initial value of $4,250, consist of donor restricted funds of which the corpus is to be held in perpetuity. These funds consist of the equity securities in an endowment fund.

2. Land, Building, and Equipment

A summary of land, building, and equipment, and the related allowance for depreciation follows:

	December 31 1997	1996
Land	$ 141,247	$ 141,247
Building and improvements	647,683	635,585
Furniture and equipment	268,663	268,662
	1,057,593	1,045,494
Less allowance for depreciation	(492,106)	(463,478)
	$ 565,487	$ 582,016

3. Future Minimum Rentals Under Operating Leases

WVSMA leases office and computer equipment under noncancellable operating leases with terms of one year or more. A schedule by years of minimum future rentals follows:

December 31, 1997:	
1998	$40,145
1999	14,087
2000	575
Total minimum future rentals	$54,807

Total minimum future rentals do not include contingent rentals which may be assessed under the office equipment lease on the basis of usage in excess of stipulated minimums.

Rental expense in 1997 and 1996 approximated $50,500 and $43,600, respectively.

4. Note Payable to Bank

Terms of the agreement underlying the note payable to bank provide for interest at 1% above the annual percentage yield of certificates of deposit and other balances, if any, securing the loan. The note is repayable in 60 monthly installments of $5,200 (including principal and interest) through July 1998 followed by a balloon payment or refinancing of the then outstanding loan balance. Accordingly, the entire $328,000 balance of the note payable as of December 31, 1997, matures in 1998. The loan is primarily secured by a first deed of trust on the building, which has a net book value approximating $381,000 at December 31, 1997. In addition, at December 31, 1997, the loan is collateralized by a $300,000 certificate of deposit and approximately $28,000 in a money market account.

Interest paid approximated $18,000 and $22,000 in 1997 and 1996, respectively.

5. Royalty Endorsements

Royalty endorsement income primarily consists of separate endorsement agreements with Medical Assurance (MA) and Acordia of West Virginia to allow them to market services to WVSMA's members relating to various insurance products. WVSMA recognized endorsement royalty income of $115,000 and $115,000 from MA, and $50,000 and $47,000 from Acordia of West Virginia in 1997 and 1996, respectively.

6. Retirement Plan

WVSMA is a participant in a Prototype Corporate Defined Contribution Retirement Plan (the Plan). All employees of WVSMA are covered by the Plan as long as they are at least 21 years old and have completed six months of service. WVSMA's contribution approximated $35,000 and $37,000 in 1997 and 1996, respectively, based on approximately 10% of the total compensation of all eligible participants. Employees are vested in their participant account at the rate of 20% for each completed year of service, up to 100% vesting after four years of service.

7. Income Taxes

Revenues of WVSMA are generally exempt from federal income tax under Section 501(c)(6) of the Internal Revenue Code. However, certain income, primarily advertising revenues, is considered unrelated business income and is taxable to the extent revenues exceed allocable expenses. WVSMA paid income taxes approximating $6,000 and $20,000 in 1997 and 1996, respectively.

Easter Seals making a difference in the lives of West Virginians with disabilities

West Virginia Easter Seal Information and Referral Service:

- provides individuals with disabilities information about and referral to appropriate agencies and professionals
- provides limited funding to individuals with disabilities to use toward assistive devices, evaluations and therapy.

For more information, contact:

Easter Seal Rehabilitation Center
1305 National Road
Wheeling, WV 26003
(304) 242-1390 Voice, TDD (304) 242-1390, (800) 677-1390

Prasadarao B. Mukkamala, MD

Union Square • 1 Monongalia Street • Charleston, WV 25302

Dr. Mukkamala is a Diplomate of the American Board of Physical Medicine and Rehabilitation and the American Board of Electro-Diagnostic Medicine.

Specialist in Electromyography and Nerve Conduction Studies

For appointment, call: **(304) 344-5153**

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Acordia

Acordia of West Virginia

Insurance Brokers with Answers

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One Hillcrest Drive, East
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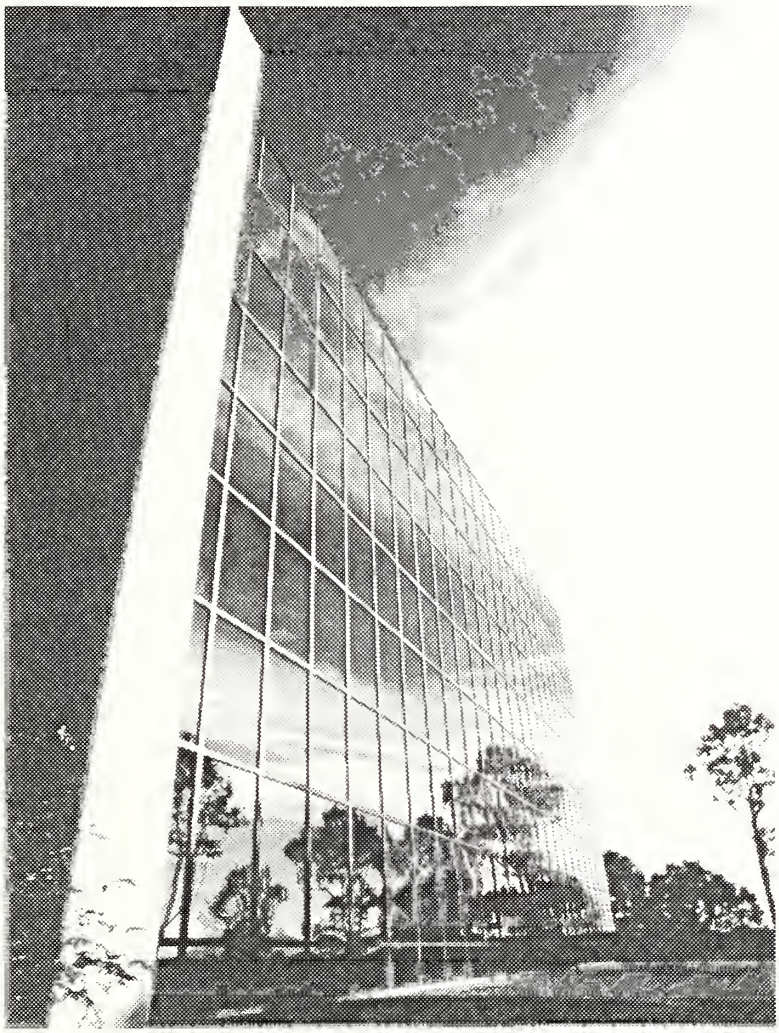

Acordia of West Virginia is the program agent for Medical Assurance. Medical Assurance is endorsed by the West Virginia State Medical Association as the carrier of choice. We have designed a professional liability program exclusively for West Virginia Physicians with protection offered by a West Virginia based A (Excellent) rated malpractice insurer.

As one of the Acordia companies, Acordia of West Virginia operates from a network of offices throughout the Mid-Atlantic Region.

For Additional Information Call: 1-800-344-5139 (Ext. 639)

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